Working together across primary care, mental health & addictions: Exploring the association between the formalization of organizational partnerships & collaboration among staff members

By

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Abstract

The purpose of this study was to explore the relationship between the formalization of inter-organizational partnerships and collaboration among staff members working together across primary care, mental health and addiction organizations to provide services to adults with complex mental health and addiction needs. Phase I of the study provided an environmental scan of existing partnerships among Family Health Teams (FHTs) and Community Health Centres (CHCs), and the Mental Health and/or Addiction (MHA) organizations they partner with, in the province of Ontario (Canada). Phase II explored the relationship between formalization and a) administrative collaboration and b) and service delivery collaboration. The hypotheses proposed that staff members who are part of formalized partnerships would report higher levels of collaboration. Phase III explored how formal and informal partnerships and collaboration are experienced by the administrative and service provider staff members who work across FHTs, CHCs and MHAs organizations. Using a mixed methods approach, data were collected using electronic surveys and telephone interviews. The results of Phase I indicated that FHTs and CHCs in Ontario have between 1-3 partnerships with MHA organizations. Most are informal partnerships, have existed for less than 5 years, and most staff members (partners) interact on a monthly basis. The quantitative results of
Phase II showed no significant relationship between formalization and either form of collaboration.

The qualitative findings from Phase III provide two key contributions. First, the results of the interviews may help explain why collaboration was not higher in formalized partnerships, as demonstrated by the range of advantages and disadvantages experienced by administrators and service providers in both formal and informal partnerships. Second, the findings illuminate factors related to the process of creating and/or formalizing partnerships, suggesting that there may be other factors that mediate or have a direct impact on the relationship between formalization and collaboration. By bringing together the study findings, the study addresses a gap in the literature by proposing a pathway through which formalization may be associated with collaboration. The results of the study provide opportunities for future research to help improve the quality and accessibility of services to adults with complex mental health and addiction needs.
Dedication

This thesis is dedicated to my loving family. Thank you to my grandparents, Marcel, Hazel, Zoltán, and especially Irene, who expanded my global vision by teaching me that “nothing is too far if you care, and nothing is too close if you don’t”. Thank you to my mother and father, Zsuzsanna Kathy and James Pauzé, for inspiring my insatiable curiosity of life and love of learning. Thank you to my siblings, Emilia, Korah, Jillian and James, for your unwavering belief (and loving harassment) that one day I might actually finish school and ‘grow up’. Thank you to my husband, Sunjay Nath, for being my life partner and guiding light; at least half of this degree belongs to you. And thank you to my three world leaders, Zander, Xaiden and Avison, for inspiring me to be the academic mom that I have become. I am grateful for your love and presence in my life.
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Although a PhD degree is conferred upon one individual, those who have walked this path appreciate the enormous contributions of the many advisors, mentors, colleagues, friends, family, and study participants, all of whom who rightfully deserve to celebrate in the completion of this journey.

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Finally, thank you to the many, many individuals who both joined me and parted from me during this final stretch, lighting the way for my next journey.

"The two most important days in your life are the day you were born .... and the day you figure out why." ~Mark Twain

“The best use of life is to use it for something that outlasts it.”

~William James

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- TUTOR-PHC (Transdisciplinary Understanding and Training on Research – Primary Health Care), a CIHR Strategic Training Program; http://www.uwo.ca/fammed/csfa/tutor-phc/

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### Abbreviations

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHAC</td>
<td>Aboriginal Health Access Centre</td>
</tr>
<tr>
<td>AOHC</td>
<td>Association of Ontario Health Centres</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre (Ontario)</td>
</tr>
<tr>
<td>CHCC</td>
<td>Community Health Care Centre (Quebec)</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
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<tr>
<td>CMHA</td>
<td>Canadian Mental Health Association</td>
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<tr>
<td>CPQ</td>
<td>Collaborative Practice Questionnaire</td>
</tr>
<tr>
<td>ED</td>
<td>Executive Director</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee For Service</td>
</tr>
<tr>
<td>FHT</td>
<td>Family Health Team</td>
</tr>
<tr>
<td>GEE</td>
<td>Generalized Estimating Equations</td>
</tr>
<tr>
<td>HCC</td>
<td>Health Council of Canada</td>
</tr>
<tr>
<td>HPRAC</td>
<td>Health Professions Regulatory Advisory Council</td>
</tr>
<tr>
<td>IECPCP</td>
<td>Interprofessional Education for Collaborative Patient-Centred Practice</td>
</tr>
<tr>
<td>IHSN</td>
<td>Integrated Human Service Network</td>
</tr>
<tr>
<td>IHSP</td>
<td>Integrated Health Service Plan</td>
</tr>
<tr>
<td>IOR</td>
<td>Inter-Organizational Relationship</td>
</tr>
<tr>
<td>LHIN</td>
<td>Local Health Integration Network</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health and/or Addiction</td>
</tr>
<tr>
<td>MOHLTC</td>
<td>Ministry of Health and Long-term Care (Ontario)</td>
</tr>
<tr>
<td>PSAT</td>
<td>Partnership Self-Assessment Tool</td>
</tr>
<tr>
<td>RA</td>
<td>Research Assistant</td>
</tr>
<tr>
<td>THAS</td>
<td>Telephone Health Advisory Service</td>
</tr>
</tbody>
</table>
Codes

For the purpose of clarity, the following codes have been used:

1. All interview extracts are indented.

2. *Italics* are used for interview extracts.

3. [...] indicates words, phrases or sentences that have been omitted from an interview extract.

4. A word or phrase within square brackets [ ] indicates information added to make the context or meaning of an interview extract clearer.

5. Rounded brackets ( ) at the end of an interview extract gives the source of the extract.
**Glossary**

**Administrative Collaboration**: We define administrative collaboration as the combining of the perspectives, knowledge, and skills of diverse partners in a way that allows the partnerships to: “1) think in new and better ways about how it can achieve its goals; 2) plan more comprehensive, integrated programs; and 3) strengthen its relationship to the broader community” (Lasker et al., 2001; Weiss et al., 2002, p. 684). Administrative collaboration occurs between two or more individuals who engage in administrative tasks related to the planning, implementation or evaluation of partnership activities. Activities may vary, but do not involve direct patient care.

**Collaboration**: Lasker et al. (2001) define collaboration as “a process that enables independent individuals and organizations to combine their human and material resources so they can accomplish objectives they are unable to bring about alone” (p. 183). The current study conceptualizes two different forms of collaboration within an inter-organizational context: administrative collaboration and service delivery collaboration.

**Formal Partnership**: We specifically looked at whether or not two organizations (partnership dyad) shared at least one type of a formal inter-organizational agreement (dichotomous, categorical classification of formal or informal partnerships). Examples of formal agreements included: partnership agreements; memorandum of understanding; affiliation agreements; service agreements; secondment agreements; and strategic alliance agreements; bylaws; and written policies/procedures.

**Formalization**: Vlaar et al. (2007b) define formalizations as “the process of codifying and enforcing output and/or behaviour, and its outcomes, in the form of contracts, rules and procedures” (p. 439).
We have classified the formalization of inter-organizational partnerships as an outcome of the formalization process, resulting in an organizational structure (e.g., formal written agreement).

**Informal Partnership:** A relationship between two organizations that do not share at least one type of a formal inter-organizational agreement (dichotomous, categorical classification of formal or informal partnerships).

**Inter-organizational Partnership or Partnership:** In general, an inter-organizational partnership implies that two organizations agree to formally or informally work together in some way to provide services to a population of individuals, or towards a common vision or goal (Provan et al. 2007). This is contrasted with networks, which involve three or more organizations that formally or informally agree to work together towards a common vision or goal (Provan et al. 2007).

**Inter-organizational Relationship:** “[S]trategically important, cooperative relationships between a focal organization and one or more other organizations to share or exchange resources with the goal of improved performance” (Parmigiani & Rivera-Santos, 2011, p. 1109).

**Patient:** We use the term patient to refer to the intended recipient of care. Other terms used in the literature have included client, service user, and consumer.

**Service Delivery Collaboration:** We define service delivery collaboration as “an interprofessional process for communication and decision-making that through the practice of core collaborator competencies, enables the knowledge and skills of care providers from different types of organizations to synergistically influence the patient care provided”. Service delivery collaboration
occurs between two or more individuals (from different professions) who engage in the direct delivery of patient care. These staff members may be service providers, or administrators who have dual roles and also provide direct patient care.

A Note About Terminology

Three different fields of scientific inquiry are brought together to address the research problem in this study. A significant challenge experienced in reviewing the literature was related to the significant variation in the conceptualization of key terms commonly used both across and within these fields (inter-organizational development, service integration and collaborative practice). We have provided the above definitions in order to clarify the conceptualization of key terms used in this study, while acknowledging the historical challenges and debates that exist in the literature.

Other researchers have begun to differentiate terms and provide clearer definitions of key concepts, particularly in the service integration literature (Suter et al., 2007; Butt et al., 2008; Browne et al., 2007; Hayward, 2006; Provan et al., 2007) and the collaborative practice literature (Reeves et al., 2011; Reeves et al., 2010; Jelphs & Dickinson, 2009).
Chapter 1: Introduction & Background

This thesis is titled, “Working together across primary care, mental health and addictions: Exploring the association between the formalization of organizational partnerships and collaboration among staff members”. It is a study looking at the relationship between the formalization of inter-organizational partnerships and two forms of collaboration as a staff practice.

Formalization of inter-organizational partnerships is a governance mechanism used to improve organizational performance, including enhancing partnership effectiveness and efficiency. The objectives of this study are to 1) measure the association between formalization of inter-organizational partnerships and two forms of collaboration (administrative and service delivery), and 2) explore how these are experienced by the staff members who work in partnerships.

The current research study was part of a larger research project conducted through the University of Toronto, and funded by the Ontario Ministry of Health and Long-term Care (MOHLT) through the HealthForceOntario initiative. This dissertation presents the methods, data analysis, findings, discussion and conclusion that are specific to the current research study, and does not reflect the comprehensiveness of the larger research project. The research study is presented in 8 chapters. Chapter 1 introduces the thesis, the research problem and discusses practical implications, resulting in the study objectives. An overview of the Ontario context, as environmental background for the current study, is also provided.

Chapter 2 provides a review of the literature related to the study objectives and research questions. The chapter provides an overview of theoretical perspectives in inter-organizational relationships and formalization of inter-organizational relationships, and an overview of relevant conceptual and measurement frameworks, and empirical research related to the main study
variables (i.e., formalization, administrative collaboration and service delivery collaboration).

Chapter 3 presents the conceptual framework and study hypotheses that direct the current study.

Chapter 4 describes the study methods, which were completed in three distinct but related Phases. The objective of Phase I was to describe the current inter-organizational partnerships that existing Family Health Teams (FHTs) and Community Health Centres (CHCs) have formally or informally with community mental health and addictions (MHA) organizations. The objective of Phase II was to determine if formalization of inter-organizational partnership structures is associated with the level of administrative collaboration and/or level of service delivery collaboration. The objective of Phase III of the study was to explore how aspects of administrative collaboration and service delivery collaboration are experienced by the staff members who work in formal and informal partnerships.

Chapters 5-7 present the three papers that resulted from the thesis. Chapter 5 (Paper 1) presents a descriptive, quantitative research paper, providing insight into the existing inter-organizational partnerships among FHTs, CHCs and their MHA organizational partners in Ontario. Chapter 6 (Paper 2) presents a mixed method paper, and focuses on the association between formalization and administrative collaboration. Chapter 7 (Paper 3) also presents a mixed method paper, and focuses on the association between formalization and service delivery collaboration.

Chapter 8 provides a discussion of the overall study findings from both theoretical and practical perspectives, resulting in opportunities for future research. Limitations of the study are also presented, in addition to implications for organizational leaders and policy makers, and main conclusions from the study.

**The problem**

The process of integrating health systems and services has become a key strategy for maintaining and improving the accessibility and quality of health care for people living in Canada
People who live with complex health and social care needs require access to services from multiple service providers and multiple service organizations (AOHC, 2008; Boydell et al., 2008; Durbin et al., 2001; Jelphs & Dickinson, 2009; Glasby & Dickinson, 2009). A challenge has been to ensure the continuity of care for patients as they access services (Durbin et al., 2004; Durbin et al., 2006). These needs are contributing to a shift towards the development of increasingly complex interconnections among organizations and service providers, sometimes referred to as ‘integrated human service networks’ (IHSNs). Browne et al. (2007) define an IHSN as “a coalition or strategic alliance between appropriate agencies from multiple sectors (social, health, education) or funding sources (public, not for profit, private) that together collaborate and function to provide a continuum and spectrum of comprehensive services and opportunities for people of various ages with complex needs” (p. 2). Within these networks, there are often many dyadic partnerships (between two organizations), or smaller sub-networks (of three or more organizations), creating a complex, interdependent system of organizations, administrators and service providers who work together towards shared and independent goals. The integration and alignment of these efforts is critical for the delivery of quality, accessible and timely person-centred care.

Despite a growing body of evidence suggesting that integrated systems and services will lead to better health outcomes (Gillies et al., 2006; Suter et al., 2007; Craven & Bland, 2006; Provan et al., 2007; Boydell et al., 2008), reduced duplication of services (D’Amour et al., 2003), and continuity of patient care (Durbin et al., 2004; Durbin et al., 2006), how IHSNs function and why they are effective is still largely unknown (Butt et al., 2008; Browne et al., 2007; Suter et al. 2007). Given the emphasis placed on the development of organizational partnerships (Suter et al., 2007; Provan et al., 2007; Provan & Milward, 2006; Leatt et al., 2000) and interprofessional collaboration (Craven & Bland, 2006; Oandasan et al., 2006; Barrett et al., 2007; Blueprint for Action, 2007), additional research exploring the relationships among organizational structures and processes at two levels
within the inter-organizational context (i.e., administrative and service delivery), is required. Furthermore, there is a need for empirical evidence to guide decision-makers in determining if inter-organizational structures need to be formalized in order to enhance collaboration among staff members (Browne et al., 2007; Butt et al., 2008; Smith & Mogro-Wilson, 2007; Smith & Mogro-Wilson, 2008). By focusing on micro- and meso-levels of inter-organizational partnerships, researchers can provide new insights to help strengthen partnership effectiveness and efficiency.

**Study Overview**

The current study examines the association between the formalization of inter-organizational partnerships and two forms of collaboration as a staff practice: administrative collaboration and service delivery collaboration. Previous research has recommended the use of comprehensive, mixed method research designs (Ansari & Weiss, 2006; Strandberg-Larsen et al., 2009) supported by a combination of measurement tools that are aligned theoretically and conceptually, and have demonstrated reliability and validity (Ansari & Weiss, 2006; Browne, et al. 2007; Butt et al., 2008). The organizations of interest in the current study include FHTs, CHCs, and the MHA organizations they partner with, in the province of Ontario (Canada). These primary health care organizations are appropriately selected because they both have mandates to a) create community partnerships, and b) provide interprofessional, team-based services (BBT Report, 2007; Meuser et al., 2006; AOHC, 2008). Study participants include both administrators and service providers. To effectively explore the proposed relationships, the current study examines them within the context of services provided to adults with complex mental health and addiction needs. This patient population often requires services from multiple service providers and seeks services from a number of organizations (Boydell et al., 2008; Durbin et al, 2001).
The objectives of the study are to:

1. Describe the current inter-organizational partnerships that FHTs and CHCs have (formally or informally) with community MHA organizations.

2. Determine if there is an association between formalization and a) administrative collaboration, and/or b) service delivery collaboration.

3. Explore how aspects of administrative collaboration (administrators) and service delivery collaboration (service providers) are experienced by the staff members who work across FHTs, CHCs, and MHA organizations.

These study objectives address key gaps in the literature. Objective 1 provides important descriptive information about the inter-organizational partnerships that exist among Ontario FHTs, CHCs and MHA organizations. An environmental scan of this nature has not been completed to date. These data could be used to monitor ongoing development of both the quantity and quality of these partnerships, as well as inform planning activities and the further development of community partnerships. Objectives 2a, 2b, and 3 provide necessary information about the relationship between the formalization of inter-organizational partnership structures, and collaboration as a staff practice.

**Research Questions & Hypotheses**

Four primary research questions and two hypotheses were developed to address gaps identified in the literature.

**Administrative Collaboration:**

1 a) Do staff members engaged in formal inter-organizational partnerships report higher levels of administrative collaboration?
H1: Staff members in formalized inter-organizational partnerships will report higher levels of administrative collaboration, compared to those in informal inter-organizational partnerships.

Secondary research questions (exploratory):

1 b) Does the relationship between formalization and administrative collaboration vary by organizational type?

1 c) Does the relationship between formalization and administrative collaboration vary by staff role?

2) How is administrative collaboration experienced by administrators who participate in formal versus informal partnerships?

Service Delivery Collaboration:

3 a) Do staff members engaged in formal inter-organizational partnerships report higher levels of service delivery collaboration?

H2: Staff members who provide direct patient care in formalized inter-organizational partnerships will report higher levels of service delivery collaboration, compared to those in informal inter-organizational partnerships.

Secondary research questions (exploratory):

3 b) Does the relationship between formalization and service delivery collaboration vary by organizational type?

3 c) Does the relationship between formalization and service delivery collaboration vary by staff role?

4) How is service delivery collaboration experienced by service providers who participate in formal versus informal partnerships?
**Practical Relevance**

IHSNs are self-organizing, interdependent, complex adaptive systems, continuously transforming with the shifts in the external context and needs of patients. Person-centred care is now an expressed core value shared across health care organizations. Adults with complex mental health and addiction needs have a lived experience that is frustrating because they frequently require a range of services, sought across multiple organizations and among numerous human service providers. A person-centred system of care necessitates that each individual patient be received as a whole being, allowing him/her to share their experience, determine their end in mind, and co-create a plan of action to get there. A transformation at the point of care, within and across organizations, is essential.

The costs associated with mental health and addictions are staggering. Ontario spends more per capita on hospital and physician services related to mental health and addictions than all other provinces in Canada (Jacobs et al., 2010). A recent report submitted to the Minister of Health and Long-Term Care outlines a series of critical findings (MHA Advisory Report, 2010): 1) in 2007-08, more than $2.5 billion was spent on mental health and addiction services in Ontario alone; 2) the private sector spends more than $2.1 billion per year on services for people with mental health and addiction problems (e.g., disability claims, drug costs, employee assistance programs); and 3) when productivity costs are included, the cost to Ontario is more than $39 billion per year for mental illnesses and addictions.

The Minister’s Advisory Group (MHA Advisory Report, 2010) submitted a proposal to the MOHLTC on the 10-Year Mental Health and Addictions Strategy for Ontario. One goal of the strategy is to provide timely, high quality, integrated, person-directed health and other human services. This includes: integrated services for people with concurrent disorders; integrated MHA
services within primary care; services provided by teams of providers with the right mix of skills; and good system design, including community partnerships.

The MOHLTC and the Local Health Integration Networks (LHINs) are encouraging the development of community partnerships and interprofessional, team-based service delivery. By focusing on micro- and meso-levels of inter-organizational networks (dyads or partnerships), researchers can provide new insights about the inner workings of inter-organizational partnerships and their impact on service delivery processes. Ultimately, this increased understanding would help researchers better measure the intended outcomes of IHSNs and partnerships for patients, providers, organizations and the broader health system, in order to contribute to activities that enhance patient outcomes, improve performance monitoring and improve services across sectors.

With the growing recognition by government of the need to provide sufficient support for mental health services (e.g., Out of the Shadows report, Kirby, 2006; the Canadian Collaborative Mental Health Initiative1; and the Mental Health Commission of Canada2), FHTs and CHCs provide an excellent opportunity for the delivery of primary mental health care services for three key reasons. First, they are mandated (either directly from the MOHLTC or the LIHN) to create and foster community partnerships to better serve the needs of their target populations. In the context of this study, these partnerships are with community MHA organizations. Second, they use an interprofessional, team-based approach to patient care (and may employ mental health and/or addiction specialists). Third, many have identified mental health and addictions as a specific population focus (e.g., creating specialized service programs).

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1 The Canadian Collaborative Mental Health Initiative was funded through the Primary Health Care Transition Fund (Health Canada). The project developed a compelling case for improving mental health care in the primary health care setting through interdisciplinary collaboration, including collaboration among health care providers, consumers and caregivers. [www.ccmhi.ca](http://www.ccmhi.ca)

2 The Mental Health Commission of Canada is a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues. Through its unique 10-year mandate from Health Canada (2007-2017), it brings together leaders and organizations from across the country to accelerate change. [www.mentalhealthcommission.ca](http://www.mentalhealthcommission.ca)
Organizational leaders are experiencing the pressures of demonstrating partnership effectiveness and the benefits of collaborative practice, and look to evidence-based practices to guide their decision-making about the best ways to maintain and improve their partnership activities. Partnerships can be mandated, strongly encouraged, or occur organically. At a governance level, leaders struggle with determining how to implement community partnerships, specifically in terms of the formality of the relationships between organizational partners and their staff members. What is unclear is the degree to which formalized governance models of inter-organizational partnerships may lead to enhanced administrative collaboration or service delivery collaboration, two contributors to partnership effectiveness and efficiency.

**The Study Context: Ontario’s Health System Reform**

At its core, health care reform is an ongoing transformational process designed to help stakeholders (e.g., policymakers, decision makers, educators, service providers, and patients) improve the quality, access and continuity of services provided to patients and their families, in order to maximize health and wellbeing. A brief overview of recent health system reform in the province of Ontario, as influenced by larger health care reform in Canada, outlines environmental, social and political pressures that shape and impact the nature of inter-organizational partnerships that are created (Butt et al., 2008). The focus is on understanding how concurrent reform strategies in the primary care, mental health and addictions systems have become increasingly interdependent over time as shared visions and goals have become more clearly defined and key stakeholders have joined together in the transformation process.

In 2000, the First Ministers and subsequent key policy reports clearly positioned primary health care reform as the cornerstone of Canada’s health reform strategy (e.g., Kirby, 2002; Romanow, 2002; 2003 First Ministers Accord). Since this time, a proliferation of primary health care models has occurred in an attempt to enhance primary health care services across Ontario (Olsen et
al., 2007). From a mental health and addictions perspective, Hartford et al. (2003) provide a summary of four decades of reform in Ontario, emphasizing themes such as decentralization, de-institutionalization, and disorganization in system-level planning. Wiktorowicz (2005) provides a description of barriers experienced by communities in keeping up with the MHA reform strategies in Ontario, including: successive arm’s length governance strategies (lacking an appropriate level of authority to institute change); a lack of political willingness to allocate appropriate funds to the community; a neglect to transfer political responsibility for the coordination of care to local networks; insufficient engagement of the policy community in developing and implementing policy strategies; and the overall complexity of cross-jurisdictional, community-based care.

In Ontario, there have been three important changes related to the process of integrating primary care, mental health and addiction services: 1) move to a regionalized system; 2) implementation of FHTs, and expansion of the number of CHCs; and 3) shifting of MHA service delivery to community-based settings (including primary care). In addition, two policy changes are shaping activities pertaining to integration: a greater emphasis on partnerships among community organizations; and the need for interprofessional collaboration and teamwork among service providers who work together both within and across organizational boundaries. As a result, community partnerships and/or interprofessional collaboration have in some cases, become requirements for certain funding programs, and organizations have included partnerships and collaborative practice as part of their strategic directions and planning for the upcoming years.

**Regional Planning: Ontario LHINs & their IHSPs**

In 2006, the Ontario MOHLTC created 14 LHINs (through the Ontario Local Health System Integration Act), shifting the planning, funding and integration of health service responsibilities from a provincial to a regional level. LHINs are considered the local decision-makers with respect to services within each community, for a defined set of health service provider organizations; they do
not provide direct services. Collectively, the LHINs oversee approximately $20.3 billion health care dollars. CHCs and MHAs organizations are included in the list of health service organizations (among others); FHTs are not, and still receive their direction and funding from the MOHLTC.

Since 2006-07, LHINs have been working with organizations in their communities to develop new programs, strengthen existing programs, and foster community partnerships to improve mental health and reduce addictions (as one population of focus). The first major initiative of the LHINs was to develop Integrated Health Service Plans (IHSPs). The IHSP is a three-year strategic plan that is aligned with provincial strategic directions provided by the MOHLTC. IHSPs provide a foundation for LHIN planning initiatives and include integration priorities and action plans for creating an accessible, coordinated and integrated local health system. Each LHIN develops their own unique IHSP in collaboration with their community, local health service providers, and key health partners.

Bhasin and Williams (2007) provide a snapshot of the first IHSPs released in 2007 (the second round of IHSPs were developed at the end of 2009, for the period 2010-2013; a summary is not yet available). One LHIN identified mental health and addictions as a special population, and 12 LHINs identified population-specific strategies related to mental health and addictions. A collaboration of MHA organizations conducted a more focused review of the IHSPs, to assess the degree to which the IHSPs address mental health and addiction issues (Addictions Ontario et al., 2007). The key findings suggested that every LHIN addresses this population to some extent and that mental health and addictions was a priority for 7 LHINs and a sub-priority for 5 LHINs. However, the authors reported that access, integration and service gaps were not consistently addressed, and overall, the authors suggested that the LHINs do not adequately understand the context for mental health and addiction services and needs of these patients (Addictions Ontario et al., 2007).
Interprofessional Primary Health Care Models: CHCs & FHTs

Olsen et al. (2007) identify CHCs and FHTs as the main interdisciplinary, primary care delivery models in Ontario. The CHCs in Ontario are non-profit, community-governed organizations that are sponsored and managed by community boards (including: CHC satellites; and Aboriginal Health Access Centres or ‘AHACs’). CHCs have a history of providing interprofessional services and working with community partners (established in the 1970’s). In 2006, when the MOHLTC created the LHINs, governance of the CHCs shifted to a regional/local level.

In 2005, the MOHLTC announced new interprofessional team-based, primary care organizations, Family Health Teams. FHTs are designed to develop links with community partners and enhance primary healthcare services using a quality improvement approach. FHTs operate using one of three governance models: 1) community-based; 2) provider-based; or 3) mix of community- and provider-based (MOHLTC, 2006), defined as follows. *Community-based*: a registered non-profit organization governed by a board of directors including community representatives. *Provider-based*: an organization built of partnerships, professional corporations (for professions governed by the Regulated Health Professionals Act) or individual providers working together through a contract of association. They are governed by an executive team or established as a non-profit corporation, governed by a board of directors. *Mixed* (community and provider): groups or individuals who come together through a contract of association, and are governed by an executive team or a non-profit corporation that is governed by a board of directors. FHTs receive their funding from, and report directly to the MOHLTC, and are not included as part of the LHIN funded health service organizations.

Distinguishing features of the FHTs and CHCs are reported in Table 1. While CHCs have been in operation longer than FHTS, these organizations share two features that are necessary for the current study, including mandates to create community partnerships and provide interprofessional, team-based services.
Table 1: Comparison of CHC and FHT Primary Care Models

<table>
<thead>
<tr>
<th></th>
<th>Composition</th>
<th>Characteristics</th>
<th>Physician Compensation Model</th>
<th>Non-Physician Compensation Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHCs</td>
<td>• Interdisciplinary</td>
<td>• Regular &amp; extended hours</td>
<td>• Blended salary</td>
<td>• Salary</td>
</tr>
<tr>
<td></td>
<td>• Non-profit</td>
<td>• Targets one or more priority groups/ vulnerable populations</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>organizations</td>
<td>• Emphasis on broad determinants of health</td>
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<td></td>
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<tr>
<td></td>
<td>• Community</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>governance</td>
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<td></td>
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<tr>
<td></td>
<td>• Integration with</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>social services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FHTs</td>
<td>• Interdisciplinary</td>
<td>• Regular &amp; extended hours</td>
<td>Three options:</td>
<td>Options:</td>
</tr>
<tr>
<td></td>
<td>• 3 options for</td>
<td>• Nurse-staffed THAS</td>
<td>• Blended capitation model</td>
<td>• Salary</td>
</tr>
<tr>
<td></td>
<td>governance (community-</td>
<td>• Patient enrolment required</td>
<td>(to groups with 3 or more</td>
<td>• Sessional funding</td>
</tr>
<tr>
<td></td>
<td>based; provider-</td>
<td>• Electronic medical records</td>
<td>physicians)</td>
<td>• Contractual arrangement</td>
</tr>
<tr>
<td></td>
<td>mixed)</td>
<td></td>
<td>• Blended complement model</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(to groups with 1-7 physicians in specific defined areas of Ontario)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Blended salary compensation model (available to community-led governance FHTs &amp; mixed governance FHTs)</td>
<td></td>
</tr>
</tbody>
</table>

Note: This table was modified from Olsen et al. (2007, p. 47-49). Terms: FFS (fee-for-service); THAS (Telephone Health Advisory Service). THAS is a phone health service, staffed by registered nurses, dedicated to ensuring that patients have access to primary care services after-hours and on weekends/holidays.

Partnership Activities Among FHTs, CHCs, and MHA Organizations

Inter-organizational partnerships bring together staff who work across organizations, and foster relationships among providers who work collaboratively to provide services to shared patients. The following section provides an overview of the partnership activities among FHTs, CHCs and MHA organizations in Ontario. Few studies have reported the partnership activities of CHCs and MHA organizations, and most of the available information was found in non-peer reviewed sources. Since FHTs are relatively new organizations, data about their partnership activities, as well as overall
effectiveness, and impact on patient outcomes and system performance, are very limited or not existent (Rosser et al., 2011). In short, no known studies have explicitly conducted an environmental scan of the existing partnerships among CHCs, FHTs and MHA organizations in Ontario.

**Partnership Characteristics of CHCs**

In their 2008 report “Everyone Matters”, the Association of Ontario Health Centres (AOHC) provided a cross-sectoral analysis of Ontario’s CHCs, including patient population profiles, health professionals, and community partnerships (AOHC, 2008). The overwhelming majority of CHCs use the same clinical information system, helping to standardize data collection. The results were provided in an aggregate format, with limited descriptive data – however, three key themes were noted. **First**, many patients of CHCs have complex needs, as demonstrated by the number of providers a patient may see in a single visit (e.g., in 2006-07, over 8,000 clients saw more than 4 providers in a single visit). **Second**, in examining the patient populations distributed by LHIN region, 9 of 13 LHINs identified the mental health and addictions population as a priority (one LHIN does not have CHCs). **Third**, the report describes how almost all CHC activities (i.e., programs, services and community initiatives) involve partnerships with other community and/or health service providers. CHCs define partners as “organizations that CHCs work closely with to jointly operate programs and services or work on joint planning or advocacy initiatives to benefit their communities” (AOHC, 2008, p.29). The 54 CHCs that were surveyed reported over 1,275 partnerships in total, with an average of 24 partners per CHC. Approximately 50-75 of the total partnerships were reported to be with MHA organizations (an exact number was not provided), suggesting very limited partnerships with this group as of 2008. Primary care organizations (such as FHTs) were not an explicit partnership category provided in the report.
The AOHC commissioned a report in 2010 to describe the broad system integration activities of CHCs (AOHC, 2010) (in this context, integration refers to partnerships). An electronic survey was administered to all CHCs between May and June 2010; 56 surveys were received (76% response rate). Key findings from the survey were organized into four categories: CHC integration profiles; role of the LHIN; effectiveness of integration initiatives; and integration elements (i.e., structural elements; process elements; leadership elements; and collaboration elements).

The CHC integration profile demonstrated that CHCs average 17 partnerships, with a range of 0-80. This average is below what was reported previously (AOHC, 2008). Approximately 96% of current CHC integrations were coordination or partnership activities (versus transfers, mergers, amalgamations or starting/ceasing services). The types of stakeholders CHCs partner with were split roughly 50-50% between LHIN and non-LHIN funded organizations/services. The types of inter-organizational agreements reported by the CHCs included: partnership agreements, memorandum of understanding, letter (visiting professional agreement), collaborative agreement, and service agreement. Regarding the role of the LHIN in the partnerships, 45% of the initiatives reported no LHIN involvement. When asked to rate the effectiveness of the integration initiative, 69% were rated as either very good or excellent (30% were rated as very good, 39% were rated as excellent).

CHCs were asked to describe four integration elements, which were examined, optimized or incorporated for each integration initiative. In terms of structural elements, human resources (63.3%), comprehensive range of services (63.3%) and performance indicators (54.4%) were the top three elements reported (versus co-location, non-financial resources, financial resources, accountability agreements, information systems, governance, or incentives). Regarding a variety of process elements, joint planning (reported by 76.7% of CHCs), knowledge transfer (68.9%) and referrals (61.1%) were the top 3 reported (versus shared standards or protocols, resource matching, single-entry point, case coordination, or case management).
In terms of the leadership elements, coordination of communication (80.0%), managing inter-organizational relationships (74.4%), and fostering trust and respect (74.4%) were the top three elements most reported (versus providing community leadership, champion vision, inspire innovation, build and maintain shared culture, and lead and manage health human resources). And finally, reports on the collaboration elements (aligning with interprofessional collaboration core competencies) ranged from 81-97.8% (i.e., shared goals, willingness to collaborate, understanding of roles and responsibilities, communication, mutual trust, and mutual respect; reported from highest to lowest percentages, respectively). Shared goals (97.8%), willingness to collaborate (96.7%) and understanding roles and responsibilities scored among the top three elements, overall underscoring the importance of relationships. Collaboration in this context was not specific to the service delivery level, and referred to collaborative relationships in general.

Overall, these two key reports (AOHC, 2008; AOHC, 2010) provide the only available insight into the recent partnership activities of CHCs in Ontario. The results provide several insights: 1) CHCs have a history of working with community partners; 2) overall perceptions of the quality of the partnerships were high as were perceptions of collaboration among staff members; and 3) examining structural, process, administrative and relationship elements is important to understanding partnerships. The report completed a fairly high level overview of the existing integration/partnership activities. The report did not provide detailed information about the following partnership characteristics: specific partnership activities with MHA organizations; level of activity within partnerships; details about the administrative or service ties included within the inter-organizational agreements; nature of the formality of the partnerships; or the length of the partnerships. The current study aimed to gather this missing information to provide a complementary review of the CHC and FHT partnership activities with MHA organizations.
Partnership Characteristics of FHTs

FHTs were created during a period of significant reform in mental health and addictions services in Ontario, with a particular emphasis on strengthening the delivery of these services within primary care settings. The interprofessional approach to service delivery has naturally positioned FHTs as ideal for patients requiring access to MHA services within the community. Some researchers suggest a growing emphasis on integrating MHA services and community partnerships (Mulvale & Bourgeault, 2007; Mulvale et al., 2008; Sherman et al., 2010), while there is also an interest in FHTs regarding interprofessional collaboration more broadly (Goldman et al., 2010a; Goldman et al., 2010b; Howard et al., 2011; Rosser et al., 2011). Overall, few studies have examined the partnership activities of FHTs, described below.

Researchers have identified contextual factors that affect collaboration among service providers who work together to offer primary mental health care services (Mulvale & Bourgeault, 2007). The authors provided insights into a variety of within-team barriers and facilitators, but did not discuss how to facilitate collaboration or partnerships across organizations. In a follow-up study, the researchers applied this framework in more detail within the FHT context, using qualitative methods to explore how the contextual factors were experienced by FHT service providers (Mulvale et al., 2008). In examining the local health system factors, the authors reported that many FHTs had developed linkages with MHA organizations, emphasizing the need for community-wide service planning. However, descriptive characteristics about the nature of these types of partnerships were not reported.

More recently, a group of researchers conducted a mixed methods study in northern Ontario to explore the integration of mental health and psychiatric services within FHTs (Sherman et al., 2010). The study did not examine the nature of partnerships that FHTs had with MHA organizations, nor did it appear to have a focus on addictions. However, 19 FHTs did provide
information through structured telephone interviews about the following: FHT membership and practice characteristics; integration of mental health services into the FHTs; and education and training needs related to mental health services. One relevant finding was the importance of pre-existing organizational relationships. Researchers indicated that in some cases, FHTs were created with “little more than a name change and new staff” (Sherman et al., 2010, p. 11). While not surprising, it is an important consideration when identifying partnerships and partnership characteristics (e.g., length of partnership; where the length of the partnership may be perceived to be longer than the year the FHT was established). A second finding was that respondents did not always view physicians as part of the organization, since many physicians have a separate corporate structure. This sense of separation may have implications for perceptions of level of collaboration, and could also have an impact on relationships with service providers who are from other MHA organizations.

**Partnerships, Collaboration & Community-Based MHA Services**

In an attempt to provide a more comprehensive review of the existing transformation of health services for adults with mental health and addiction needs, we examined the MHA reform activities in more detail, with a particular emphasis on inter-organizational partnerships and interprofessional collaboration. Several reports provide an overview from the MHA system perspective (Boydell et al, 2008; Addictions Ontario et al., 2010; Durbin et al., 2001; Reville, 2006; Select Committee, 2010; Minister’s Advisory Group, 2010; Newman, 1998). The reports consistently emphasized the importance of community partnerships and collaboration as key strategies to improve access to services and improve the quality of person-centred care.

The shift towards delivering mental health and addiction services within the community setting has been a key strategy used to improve the experience and health outcomes of Ontarians (Newman, 1998). Given the historical challenges related to mental health reform in Ontario
(Hartford et al., 2003; Wiktorowicz, 2005), it is not surprising that the current state of mental health and addiction services in Ontario is not meeting the needs of individuals with mental health or addiction needs. There are concerns related to: the increasingly narrow definitions of mental health (where disorders are being prioritized and some receiving little or no attention – i.e., moderate mental illness) (Dewa et al., 2003); regional disparities of services (Wiktorowicz, 2005); and the complex nature of mental health needs, especially for individuals with serious mental illness. Themes that overlap the recommendations made to better meet the needs of this population include: addressing system level finances, structures and human resources; and increasing the role of the government to develop collaborative care models that integrate physical and mental health care (Dewa et al., 2003).

Initial efforts to bring together primary care, mental health and addictions services resulted in the development of primary mental health care models (historically called ‘shared care’) (Kates et al., 2011). This approach has become increasingly popular because of the benefits associated with collaborative, interprofessional teams, as well as the need to increase access to mental health and addiction specialists (Gnam, 2001; Craven & Bland, 2006; Durbin et al., 2001; Kates et al., 2011). Some of these models of care can be considered forms of service integration or partnerships, but have been typically conceptualized at the individual service provider level (i.e., originating between family doctors and psychiatrists, and now expanded to include a broad range of service providers) rather than at an organizational level (i.e., inter-organizational partnerships). Not all models are created alike, and the depth of interprofessional collaboration among providers varies widely (Kates et al., 2011; Kates & Ackerman, 2002; Pauzé & Gagné; 2005; Pauzé et al., 2005).
Chapter 2: Literature Review – Association Between Formalization & Collaboration

Introduction
The purpose of the literature review was to explore the possible association between the formalization of inter-organizational partnerships and the level of collaboration among staff members who work together across organizations. Two forms of collaboration as a staff practice were considered: administrative collaboration and service delivery collaboration. The review brings together three fields of scientific inquiry: inter-organizational development, service integration, and collaborative practice (also called interprofessional practice or interprofessional care). The nature of the research problem examined in this study requires that we consider the association between formalization and collaboration through these different lenses.

Four primary questions guided the literature review process.

1. What theoretical perspectives currently guide our understanding of inter-organizational relationships, and the possible association between formalization and collaboration among staff members?

2. What conceptual and/or measurement frameworks currently guide our understanding of inter-organizational partnerships, formalization and collaboration among staff members?

3. What evidence is there to suggest an association between the formalization of inter-organizational partnerships and collaboration among staff members?

4. What other factors influence the collaborative processes among staff members who participate in inter-organizational partnerships?

We begin with the approach to the literature review and then review the main theoretical perspectives, conceptual frameworks and models that are available in the literature and are relevant to the current study. The theoretical literature will inform this thesis in two ways. First, we
present a brief review of the theoretical literature to answer three foundational questions: “Why do organizations form inter-organizational relationships (IORs)?”, “Why do organizations formalize their partnerships?”, and “Why might the formalization of partnerships be related to collaboration?” Answering these questions provides an understanding of both the economic and social drivers that influence the relationships that develop among organizations and the staff members who work across these organizational boundaries. Second, in Chapter 8 of the thesis, theoretical perspectives are revisited to further discuss and explain the results of the data analysis presented in Chapters 5-7 of the thesis, providing a possible pathway through which formalization may be associated with collaboration.

Following, we provide reflections that are specific to formalization and collaboration, illustrating tensions in how the variables are defined and measured. These discussions and observations prepare the reader for the presentation and discussion of the main empirical studies and their findings, as they help to explore the possible association between formalization and collaboration. Finally, we present a short overview of the additional factors (beyond formalization) that may be associated with collaboration. Although the current study does not examine these factors, they are presented as additional context for the reader, since it is unlikely that formalization is the only factor that may be associated with collaboration. We conclude by summarizing the main observations and challenges that emerged from the review, and identifying opportunities for the current study to build on previous research.

**Approach to the Literature Review**

A review of the literature was completed using the University of Toronto’s online catalogue. Keywords and search strategies are presented in Table 2. The databases that were used for the literature review included: PsychInfo, Medline, and CINAHL.
The inclusion criteria consisted of papers that related directly to literature review questions presented above, that had an abstract, that were available in English, and that were available directly or indirectly through the University of Toronto Holdings. More than 600 articles were generated from this initial search strategy, and additional selection criteria were applied.

Table 2: Search Strategy and Keywords

<table>
<thead>
<tr>
<th>Search strategy</th>
<th>Keywords</th>
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<tbody>
<tr>
<td>1</td>
<td>Partnerships or networks</td>
</tr>
<tr>
<td>2</td>
<td>Inter-organizational or inter-agency or interorganizational relationships</td>
</tr>
<tr>
<td>3</td>
<td>Formalization or formal or formalized</td>
</tr>
<tr>
<td>4</td>
<td>Collaboration or teamwork or cooperation</td>
</tr>
<tr>
<td>5</td>
<td>Interprofessional or interdisciplinary or collaborative practice or interprofessional care</td>
</tr>
</tbody>
</table>

Papers were selected if they had a focus on or relevance to at least one or more of the main study variables (i.e., formalization, administrative collaboration, or service delivery collaboration), and preference was given to articles with a focus on health services research. Articles were excluded if they were considered irrelevant to the study (i.e., did not relate to at least one of the main study variables, or were not relevant to health services research). Key articles were then identified and retrieved in full, and references were hand searched for additional relevant articles. A review of grey literature was also conducted using Google Scholar, with similar search parameters. Relevant abstracts were identified and grouped according to common themes: theoretical perspectives, conceptual and/or measurement frameworks or models; inter-organizational partnerships; formalization; administrative collaboration; and service delivery collaboration.

**Theoretical Perspectives**

**Why do Organizations Form IORs?**

An inter-organizational partnership is one type of a variety of possible IORs. There are two main theoretical perspectives that have been used to understand why IORs are formed: organizational economics and organizational theory (see Figure 1 for a summary).
In organizational economics (or rational choice theories), the theoretical paradigms used to explain the formation of IORs primarily focus on exchanges or interactions between organizations. Essentially, theories sharing this perspective argue that IORs form when it is more efficient for an organization to conduct activity through a close partner relationship than on its own, or through the market. Examples of theoretical paradigms include: transaction cost economics, resource-based view, and agency theory. In organizational theory (social choice theories), the theoretical paradigms used to explain the formation of IORs primarily focus on relationships and shared values (other than exchanges or interactions). Theories sharing this perspective argue that the formation of IORs is often based upon prior relationships, trust, and histories between the partners. Organizations form IORs to gain legitimacy, status or reputation based on their connections, or to reduce dependency and uncertainty. Examples of theoretical paradigms include: resource dependence theory, stakeholder theory, institutional theory, and social networks theory.

Figure 1: Two Differing Perspectives on Why Organizations Form IORs

Organizational Economic Perspective
- Economic Efficiency

Organizational Theory Perspective
- Legitimacy
- Status
- Reputation
- Reduced dependency
- Reduced uncertainty

Improved Organizational Performance

No single theory is sufficient in anticipating or explaining the complexities of the IORs created by organizations (Barringer & Harrison, 2000; Hill & Lynn, 2003; Parmigiani & Rivera-Santos,
Thus, researchers must bring together appropriate combinations of theories to develop and test their hypotheses, as organizations are likely to form IORs for both economic and social/relationship purposes. In addition, organizational leaders will also anticipate and experience both advantages and disadvantages to participating in IORs – and over time, these experiences provide a feedback mechanism to influence their future decisions to engage in IORs (why) as well as the process (how). Barringer and Harrison (2000) completed a review of the literature and summarize key advantages and disadvantages to participating in IORs (Table 3).

**Table 3: Potential Advantages and Disadvantages of Participation in IORs**

<table>
<thead>
<tr>
<th>Potential Advantages</th>
<th>Potential Disadvantages</th>
</tr>
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<tbody>
<tr>
<td>• Gain access to a particular resource</td>
<td>• Loss of proprietary information</td>
</tr>
<tr>
<td>• Economies of scale</td>
<td>• Management complexities</td>
</tr>
<tr>
<td>• Risk and cost sharing</td>
<td>• Financial and organizational risks</td>
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<tr>
<td>• Gain access to a foreign market</td>
<td>• Risk becoming dependent on a partner</td>
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<tr>
<td>• Product and/or service development</td>
<td>• Partial loss of decision autonomy</td>
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<tr>
<td>• Learning</td>
<td>• Partners’ ‘cultures’ may clash</td>
</tr>
<tr>
<td>• Speed to market</td>
<td>• Loss of organizational flexibility</td>
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<tr>
<td>• Flexibility</td>
<td>• Antitrust implications</td>
</tr>
<tr>
<td>• Collective lobbying</td>
<td></td>
</tr>
<tr>
<td>• Neutralizing or blocking competitors</td>
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</tbody>
</table>

Note: Modified from Barringer and Harrison (2000, p. 385-386).

**What Are the Different Forms and Types of IORs?**

Reviewing the different types of IORs that are created by organizations helps us to understand the distinction between perspectives that view IORs as exchanges (traditional view) versus those that view IORs as social relationships (a more modern view). However, as argued by Parmigiani and Rivera-Santos (2011), it is not sufficient to categorize forms of IORs into theoretical perspectives (one or another); rather it is more important to understand the intent of the IOR – that is, the reason why the relationship is created in the first place.

Parmigiani and Rivera-Santos (2011) bring to the forefront the inherent tension that is experienced by organizations as they simultaneously pursue both co-exploration and co-exploitation activities (in the form of various IORs) to improve organizational performance. This tension is
affected by the rationale for creating an IOR, and influences the form of the IOR selected (or combinations of IORs selected, since many organizations engage in multiple and simultaneous relationships). Co-exploration is defined as “a strategically important, cooperative relationship to create new knowledge, tasks, functions, or activities. Its focus is on new knowledge, and its main activity is learning and innovation” (Parmigiani and Rivera-Santos, 2011, p. 1122). Co-exploitation is defined as “a strategically important, cooperative relationship to execute existing knowledge, tasks, functions or activities. Its focus is on existing knowledge, with expansion as the main activity” (Parmigiani and Rivera-Santos, 2011, p. 1122). More simply, co-exploration activities focus on benefiting from ‘new’, while co-exploitation activities focus on benefiting from what already exists.

Beyond these two pure forms of IORs, researchers have identified various types of IORs and their characteristics or attributes (e.g., alliance, joint venture, buyer-supplier agreement, franchising, cross-sector partnership, network, consortia, or interlocking directorate) (Parmigiani & Rivera-Santos, 2011; Barringer & Harrison, 2000). For the purposes of the current study, we focus on networks and dyads or partnerships, which are considered the basic building blocks of multi-organizational networks.

**How Might the Rationale for Engaging in an IOR Influence the Type of IOR Selected?**

As mentioned, each theoretical perspective (e.g., organizational economics) and corresponding series of theoretical paradigms (e.g., transaction cost economics) can be applied to understanding why and how organizations engage in both pure forms of IORs (i.e., co-exploration or co-exploitation). Parmigiani and Rivera-Santos (2011) provide examples of how co-exploration and co-exploitation can be explained by seven of the most predominant theoretical perspectives used by inter-organizational development researchers (see Table 4).
Table 4: Key Constructs of Theories Addressing Pure Forms of IORs

<table>
<thead>
<tr>
<th>Theory</th>
<th>Description</th>
<th>Co-Exploration Activities</th>
<th>Co-Exploitation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organizational Economic Perspective (Rational Choice)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transaction cost economics</td>
<td>Focuses on how an organization should organize its boundary-spanning activities so as to minimize the sum of its production and transaction costs.*</td>
<td>Create a new specific investment</td>
<td>Exploit an existing specific investment</td>
</tr>
<tr>
<td>Resource-based view</td>
<td>An organization is a bundle of resources and capability. Organizations develop firm-specific valuable resources, capabilities, competences, and dynamic capabilities, helping them build a competitive advantage and profitability. **</td>
<td>Combine resources possessed by the partners to create new resources</td>
<td>Leverage resources possessed by the partners</td>
</tr>
<tr>
<td>Agency theory</td>
<td>Organizations align incentives between principals (those who sponsor or govern the org) and agents (those who produce the services). **</td>
<td>Contract to split the proceeds of knowledge created through the IOR</td>
<td>Contract to split the proceeds generated through existing knowledge</td>
</tr>
<tr>
<td><strong>Organizational Theory Perspective (Social Choice)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource dependence</td>
<td>A theory rooted in an open system framework that argues that all organizations must engage in exchanges with their environment to obtain resources.*</td>
<td>Reduce uncertainty through greater control of creativity, the most important resource in the IOR</td>
<td>Reduce uncertainty through greater control of capacity, the most important resource in the IOR</td>
</tr>
<tr>
<td>Stakeholder theory</td>
<td>Organizations are at the centre of an interdependent web of stakeholders and have a responsibility to consider the legitimate claims of their stakeholder when making decisions and carrying out business transactions.*</td>
<td>Develop reputation with new or different stakeholders on new or different issues</td>
<td>Transfer, protect, and leverage reputation with known stakeholders on known issues</td>
</tr>
<tr>
<td>Institutional theory</td>
<td>Suggests that institutional environments impose pressures on organizations to appear legitimate and conform to prevailing social norms. *</td>
<td>Gain legitimacy in an environment characterized by new or underdeveloped institutions</td>
<td>Leverage and transfer existing legitimacy in an environment characterized by known institutions</td>
</tr>
<tr>
<td>Social networks</td>
<td>Emphasizes an organization’s position in the social structure and includes the importance of embeddedness based on relationships between individuals. Organizations are tied to others based upon both repetitive market relations and social contracts that entail its network structure. **</td>
<td>Use ties to exchange tacit knowledge and learn, with trust defined as not taking advantage of vulnerabilities</td>
<td>Use ties to find compatible partners for a given activity, with trust defined as dependability and reliability</td>
</tr>
</tbody>
</table>

What Parmigiani and Rivera-Santos (2011) have contributed to the literature is an appreciation for how different types of IORs contribute to tensions experienced in the planning and implementation of IORs, as organizations focus on improving performance. For example, creating a partnership (type of IOR) could result in both co-exploration and co-exploitation activities, depending on the intention for forming the partnership in the first place. In a cross-sector partnership, co-exploration activities could focus on how bringing together stakeholders could spark new knowledge creation. On the other hand, co-exploitation activities could simultaneously focus on leveraging existing connections that are distinct to each partnering organization. Thus, not only do organizations have to balance the tension between co-exploration and co-exploitation within a single partnership due to competition for scarce resources, but also across multiple partnerships (or other types of IORs) that they may simultaneously be engaged in. The formalization of inter-organizational partnerships may be a strategy used by managers to balance these tensions. In addition, formalization may be a strategy used to better manage multiple IORs and/or improve organizational performance.

**What Does the Formalization of IORs Look Like?**

Formalization of IORs has been defined as both a *process* of documenting and enforcing behaviours and outcomes, and an *outcome* of this process in the form of contracts, rules, procedures or other documentation. Vlaar et al. (2007b) define formalizations as “the process of codifying and enforcing output and/or behaviour, and its outcomes in the form of contracts, rules and procedures” (p. 439). In the current study, we classify formalization as an organizational structure and feature of organizational governance.

Formalization is not a type of IOR, but considered an IOR mechanism (often a characteristic of organizational governance). Hill and Lynn (2003) completed a review of the literature and provide examples of governance mechanism on a continuum from rational mechanisms (aligned
with organizational economic perspectives) to relational mechanisms (aligned with organizational theory perspectives) (see Figure 2). While the examples correspond to theoretical perspectives, they do not necessarily correspond directly with types or degrees of formalization. They do however, represent different governance mechanisms, and may be included in formalized partnership agreements, in informal partnership activities, or be part of the formalization process, which is why they are included as examples in this discussion.

Figure 2: Examples of Governance Mechanisms for IORs

<table>
<thead>
<tr>
<th>Rational mechanisms</th>
<th>Centralized functional administration</th>
<th>Coordinated eligibility standards</th>
<th>Joint or inter-agency planning division of labour or responsibility</th>
<th>Case management</th>
<th>Procedures for information sharing</th>
<th>Joint agreement concerning best practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial contracts that have provisions for fund transfers and reallocations</td>
<td>Coordinated personnel qualification standards</td>
<td>Task forces, advisory groups, committees that review or approve plans and actions</td>
<td>Multi-agency, multi-task, or multi-discipline service plans and budgets</td>
<td>Cooperative monitoring or case reviews</td>
<td>Temporary personnel reassignments</td>
<td></td>
</tr>
<tr>
<td>Procedures for resolving inter-agency disputes</td>
<td>Formal inter-agency agreements to coordinate</td>
<td>Rational contracts or enforcements</td>
<td>Reprogramming authority</td>
<td>Lead agency agreements</td>
<td>Shared human capital or physical assets</td>
<td></td>
</tr>
<tr>
<td>Performance management</td>
<td>Single application form or process</td>
<td>Negotiation</td>
<td>Co-location of service activities</td>
<td>Joint mission statement or principles</td>
<td>Pooled resources or budget contributions</td>
<td></td>
</tr>
<tr>
<td>Altering reward structures</td>
<td>Delegated coordination</td>
<td>Joint or inter-agency field enforcement teams</td>
<td>Joint training or retraining, cross-training</td>
<td>Alliances and partnerships based on shared values</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continuity of care</td>
<td>Training or empowerment by an external authority</td>
<td>Leadership</td>
<td></td>
</tr>
</tbody>
</table>

Note: Modified from Hill and Lynn (2003, p. 76).
Researchers who share traditional perspectives on formalization have attempted to determine the best governance mechanism for IORs, given the organizational characteristics, rationale for forming the IOR and environmental (contextual) factors – essentially an attempt to find the ‘best fit’. Vlaar et al. (2007b) observe that researchers applying a traditional perspective also tend to align with organizational economic perspectives. In an attempt to provide a complimentary and more holistic view, Vlaar et al. propose a dialectic perspective on formalization.

Their approach is based on four key principles: simultaneity, locality, minimality and generality (Vlaar et al., 2007b). The **simultaneity principle** suggests that the formalization of IORs is grounded on the interplay between the functions and dysfunctions of formalization. The **locality principle** highlights how managers must cope with the tensions that arise from formalization. Vlaar et al. suggest that managers cannot completely solve or mitigate these tensions by ideal organizational designs (i.e., negating a ‘one size fits all or cures all’ approach). The **minimality principle** suggests that extreme levels of formalization are less desirable than intermediate levels; managers should be parsimonious in their application of formalization activities. Finally, the **generality principle** emphasizes that managers should ideally create solutions to address the tensions they experience in a way that allows them to generalize these solutions to a broad range of situations they may experience. Based on these four principles, Vlaar et al. (2007b) emphasizes that the formalization of IORs creates functions and dysfunctions (advantages and disadvantages), resulting in tensions between contradictory values that compete with each other, and shaping what formalization looks like or the level of formalization applied to an IOR.

**Why Do Organizations Formalize Their IORs?**

A simplified attempt to answer the question, “Why do organizations formalize their IORs?” is to suggest that leaders or decision makers (e.g., managers) within the organization may assume that formalization of IORs will improve organizational performance. If we consider the two main
theoretical perspectives presented previously, organizational economic theorists might hypothesize that formalization would be associated with economic efficiency, whereas organizational theorists might hypothesize that formalization would be associated with perceived legitimacy, status, reputation, decreased dependency, or decreased uncertainty. In addition, organizations may formalize IORs to mitigate the perceived disadvantages or to enhance the perceived advantages associated with engaging in IORs in general.

However, the rationale for creating IORs may not be the same rationale used to decide whether or not to formalize an IOR – suggesting a less deterministic perspective. Vlaar et al. (2007b) conducted a review of the literature and compare the theoretical perspectives on why and how the formalization of IORs unfolds. The main contribution of the paper is the emphasis on the importance of ‘managerial choice’ in selecting the degree of formalization of IORs. They propose that the decision to formalize an IOR or select a level of formalization is influenced by four factors: (1) the manager’s knowledge and past experience with formalization, (2) the characteristics of the organization (firm factors), (3) the rationale for engaging in an IOR (transaction factors), and (4) the environmental context (contextual factors). In addition, Vlaar et al. discuss how managers are also influenced both by the need and ability to formalize IORs. Formalization of IORs may also be emergent or imposed.

In the context of the current study, we conceptualize a ‘manager’ as an individual who has the decision-making authority or responsibility to determine the level of formalization of a partnership, and we acknowledge that more than one individual may be involved in, or influence the decision. A manager’s decision to formalize an inter-organizational partnership is complex, takes time, and is influenced by a number of interrelated factors. Although the current study does not examine these influencing factors in the decision-making process, they provide useful information about the context and process that occurs prior to a decision to formalize a partnership. More
specifically, it is helpful to consider the anticipated advantages and disadvantages (or functions and dysfunctions) of formalization, as they relate to collaboration among staff members who work together across the partnership.

**Why Might the Formalization of IORs Be Related to Collaboration Among Staff Members?**

The current study uses a basic structure, process, and outcome approach to conceptualize the possible relationship between formalization (structure) and levels of collaboration (process). The following section provides a brief overview of the two forms of collaboration that are considered in this study, followed by a brief introduction of a theoretical rationale for why formalization of IORs may be related to collaboration.

**What Does Collaboration as a Staff Practice Look Like?**

Collaboration as a staff practice can be defined as “a process that enables independent individuals and organizations to combine their human and material resources so they can accomplish objectives they are unable to bring about alone” (Lasker et al., 2001; p. 183). The current study conceptualizes and differentiates between two forms of collaboration that occur within IORs, specifically within a health and social care context: administrative collaboration and service delivery collaboration. We have differentiated these two forms of collaboration based on the nature of the tasks that are performed by staff members. This is a key distinction since these terms, in an inter-organizational context, are conceptualized and measured differently.

Administrative collaboration occurs between two or more individuals who engage in administrative tasks related to the planning, implementation or evaluation of partnership activities. Activities may vary, but do not involve direct patient care. Service delivery collaboration occurs between two or more individuals who engage in the direct delivery of patient care. These staff members may be service providers, or administrators who have dual roles and also provide direct
patient care. Fundamentally, collaboration looks different for administrators and service providers by virtue of their primary roles and responsibilities.

**Why Might Formalization Be Associated With Collaboration?**

We propose that the reason why formalization may be associated with levels of staff collaboration is a function of the process used to determine the level of formalization of the partnerships, the mechanisms selected and applied to support the partnership and collaboration, and the resulting effects of formalization that are experienced by staff members. The advantages and disadvantages (functions and dysfunctions) of formalization of IORs, as presented in the literature review and conceptual framework by Vlaar et al. (2007b), provide insight into the mechanism through which formalization may be associated with collaboration among staff members. Generally, functions of formalization are considered consequences that change an organization’s existing context or condition in the direction towards desired objectives, and dysfunctions of formalization contribute the opposite effect (Vlaar et al., 2007b). A summary of the advantages and disadvantages of formalization is provided in Table 5.

At an *administrative level*, formalization of partnership structures may help: clarify the coordination and communication mechanisms across organizations; outline the resources required to support the partnership; determine decision-making processes, accountability mechanisms, or liabilities; and clarify the roles and responsibilities for each of the organizational partners and the staff. In short, formalization is thought to influence factors that will lead to enhanced administrative collaboration. At a *service delivery level*, formalization of partnership structures may help: facilitate the communication among staff across organizations (e.g., sharing of patient information); provide the structure needed to facilitate the intensity or frequency of interactions among staff; and clarify the roles and responsibilities for service providers. In short, formalization is thought to enhance or facilitate the core collaborator competencies (i.e., knowledge of roles, communication, mutual trust
and respect, and willingness to collaborate; Oandasan et al., 2006), which are the foundation for service delivery collaboration.

Table 5: Advantages (Functions) and Disadvantages (Dysfunctions) of Formalization

<table>
<thead>
<tr>
<th>Factors</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advantages (functions)</td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td>Formalization as a means to achieve concerted action: (division of labour; common language/communication; signaling device; fuel interaction processes)</td>
</tr>
<tr>
<td>Control</td>
<td>Formalization as a means to restrain or direct behavior: (control of: the partner organization, deviation from objectives, process/pace setting; control from a distance; option to forgo control; trusting the partner)</td>
</tr>
<tr>
<td>Legitimacy</td>
<td>Formalization as a means to persuade and convince stakeholders: (internal legitimacy; external legitimacy)</td>
</tr>
<tr>
<td>Cognition and Learning</td>
<td>Formalization as a means to make sense: (accuracy expectations; degree of ambiguity; focusing attention; completeness and consistency; force people to reflect and think; governability of the relationship; anticipation and mind-stretching; target for contraction; induce collective learning; generation of new ideas)</td>
</tr>
<tr>
<td>Disadvantages (dysfunctions)</td>
<td></td>
</tr>
<tr>
<td>Inhibiting</td>
<td>creativity; innovation; flexibility; mutual accommodation</td>
</tr>
<tr>
<td>Reducing</td>
<td>commitment and aspirations; initiatives that fall beyond specifications</td>
</tr>
<tr>
<td>Driving out</td>
<td>intrinsic motivation</td>
</tr>
<tr>
<td>Inducing Risk</td>
<td>risk of: areas of unilateral dependence; hold-up problems</td>
</tr>
<tr>
<td>Imposing</td>
<td>high costs; incompleteness; limited enforceability</td>
</tr>
<tr>
<td>Creating Conditions</td>
<td>conditions for: data manipulation; organizational strife; short-termism</td>
</tr>
</tbody>
</table>

Note: Modified from Vlaar et al. (2007b, p. 442-443).

The review of the theoretical literature on inter-organizational development provides an important foundation for the current study. The literature is clear in differentiating two main types of theoretical perspectives that help explain why organizations create IORs (rational versus social choice) (Barringer & Harrison, 2000; Hill & Lynn, 2003; Parmigiani & Rivera-Santos, 2011). In addition, researchers who share more modern or recent approaches to understanding the complexity of IORs propose that no single theory can explain why organizations engage in
partnerships (or other types of IORs) or why they formalize their partnerships. The work by Vlaar et al. (2007b) emphasizes managerial choice in determining the level of formalization applied to a partnership, an important contribution to the discussion since it draws our attention to the decision-making process. The framework provided by Hill and Lynn (2003) helps us to understand the range of rational and relational governance mechanisms that managers may implement to support the partnership. Vlaar et al. (2007b) identify a series of advantages and disadvantages to formalization, suggesting that formalized partnerships have both benefits and drawbacks that are likely experienced by staff members.

**Conceptual Frameworks & Models**

We focused on reviewing conceptual and/or measurement frameworks that provide an overview of inter-organizational partnerships, or specifically included formalization as an organizational structure, and collaboration as a staff practice. We also included literature on networks and coalitions, if the article was determined to be relevant to the current study (see Table 6).

The conceptual frameworks fell into one of three categories; those that were theory driven, empirically driven, or combined (i.e., theory and empirically driven). We define theory driven frameworks as those that had a specific reference to one or more theoretical perspectives (either rational or relational, or a combination) (e.g., Foster & Meinhard, 2002; Sicotte et al., 2002). Empirically driven frameworks rely solely on the results of empirical research results, with little or no explicit link with a theoretical perspective (e.g., Kegler et al., 1998; Rogers et al., 1993). Many of the articles reviewed do not explicitly refer to a theoretical paradigm (or combination of paradigms) in the description of the framework or its development (e.g., Polivka et al., 1995; Florin et al., 2000; Smith & Mogro-Wilson, 2007). Dickinson (2006) provides an overview and comparison of both empirical- and theory-led frameworks used for evaluating health and social care partnerships, and
report that few of the available frameworks have been developed using a specific theoretical perspective, despite the clear need for theory-informed frameworks. Theory-led approaches are considered more recent and seem to be more appropriate because of the complexity of partnerships (Dickinson, 2006).

Table 6: Relevant Conceptual Frameworks in the Literature

<table>
<thead>
<tr>
<th>Article</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster &amp; Meinhard (2002)</td>
<td>Theory: resource dependence, transaction cost Focus: Inter-; partnerships Developed and tested a model explaining the predisposition to formalize partnerships</td>
</tr>
<tr>
<td>Butt et al. (2008)</td>
<td>Theory: complexity theory and systems theory Focus: Inter-; partnerships Developed a conceptual model of the salient attributes of IHSSPs, and identified corresponding measurement tools</td>
</tr>
<tr>
<td>Smith &amp; Mogro-Wilson (2007)</td>
<td>Theory: Not explicit Focus: Inter-; partnership Developed and tested a conceptual framework (model) on the multi-level influences on the practice of inter-agency collaboration</td>
</tr>
<tr>
<td>Sicotte et al. (2002)</td>
<td>Theory: Organizational theory Focus: Intra- Developed and tested a conceptual framework of interdisciplinary collaboration</td>
</tr>
<tr>
<td>D’Amour et al. (2004)</td>
<td>Theory: Not explicit Focus: Inter-; network Developed an organization model for the analysis of professional collaboration, applied to networks</td>
</tr>
<tr>
<td>Florin et al. (2000)</td>
<td>Theory: open systems, non-explicit Focus: Inter-; coalition Tested an organizational systems framework of coalition functioning</td>
</tr>
<tr>
<td>Rogers et al. (1993)</td>
<td>Theory: not explicit Focus: Inter-; coalition Developed and tested a conceptual framework of the predictors of coalition functioning</td>
</tr>
<tr>
<td>Polivka et al. (2001)</td>
<td>Theory: not explicit; looks like it builds on 1995 paper Focus: Inter-; partnership Developed and tested a conceptual framework on inter-agency collaboration</td>
</tr>
<tr>
<td>Polivka et al. (1995)</td>
<td>Theory: not explicit Focus: Inter-; partnership Developed a conceptual model for community inter-agency collaboration</td>
</tr>
<tr>
<td>Kegler et al. (1998)</td>
<td>Theory: not explicit Focus: Inter-; coalition Developed and tested a model of coalition functioning and effectiveness</td>
</tr>
<tr>
<td>D’Amour et al. (2005)</td>
<td>Theory: range Focus: Intra- and Inter- Completed a review of the literature and summarized the existing concepts and theoretical frameworks related to collaboration (e.g., organizational theory, organizational sociology, social exchange theory)</td>
</tr>
</tbody>
</table>
Some of the articles focus on presenting a conceptual framework or model in detail (e.g., Butt et al., 2008; D’Amour et al., 2004), while others also test the model empirically (Foster & Meinhard, 2002; Smith & Mogro-Wilson, 2007; Sicotte et al., 2002; Florin et al., 2000; Rogers et al., 1993; Polivka et al., 2001; Kegler et al., 1998). Most of the frameworks use an input-process-output structure or approach to organizing the main variables and outcomes, regardless of the theoretical basis and/or if the model was only empirically driven. Presentations of frameworks tend to focus on identifying categories (i.e., inputs and processes) and listing factors within these categories thought to be important to the framework. This results in a long list of potential factors to test, complex research designs, and limited or no consistency in measurement tools used. Very few studies attempted sophisticated enough research methods and analysis to test such complex models (e.g., Smith & Mogro-Wilson, 2007; Rogers et al., 1993).

Many of the frameworks or models provide a macro level view of partnership functioning, rather than a more focused perspective at a more micro level. For example, several frameworks identify a range of environmental, organizational and interactional or interpersonal factors thought to influence partnership functioning (e.g., Butt et al., 2008). In addition, given the macro level focus of the existing frameworks, the discussion of the rationale for the frameworks was limited, and few researchers actually propose a clear theoretical basis for the linkages between organizational structures and organizational processes, in the context of inter-organizational partnerships. We could not identify a framework that provides a clear pathway or mechanism for the association between formalization and collaboration.

Few of the papers bridge more than one discipline or area of study, which is a significant limitation of previous research, as it relates to the foundation for the current research problem. This may have contributed to the inconsistencies in the conceptualization and differentiation among different forms of collaboration. For example, collaboration is often used interchangeably to
describe organizational structures, similar to how the term ‘partnership’ is used. In addition, forms of collaboration as a staff practice are not differentiated. It is only more recently that researchers have considered how partnerships are expressed at the level of patient care and direct service delivery, rather than just at the level of the partnership or administration.

Research examining the inter-organizational partnership process is increasing in prevalence (see literature reviews by: Easterling, 2003; Woods, 2001; Wan et al., 2001; Provan & Milward, 2006). Researchers are driven by the need to determine if and how these partnerships provide an advantage over silo organizations, and how these partnerships can be effectively developed and strengthened over time. There is also a need to better understand the relationships between organizational structures (e.g., formalization) and processes (e.g., collaboration), before processes can be effectively linked to patient outcomes (Browne et al., 2007) or other aspects of partnership functioning or organizational performance more broadly. The following sections look at the conceptualization and measurement of formalization and collaboration as a staff practice.

**Formalization**

Conceptually, researchers agree that formalization is an organizational-level variable, but researchers vary in their definition and classification of formalization. Researchers describe formalization as both an organizational structure (e.g., formalized structures such as written agreements) (Florin et al., 2000; Kegler et al., 1998; Nylen, 2007; Roger et al., 1993) and an organizational process (e.g., formalization of relationships) (Foster and Meinhard, 2002; Granner & Sharpe, 2004; Polivka, 1995; Polivka et al., 2001).

Formalization, as an organizational structure, is described more specifically as a characteristic of organizational governance (Fleury, 2005; Lasker et al., 2001; Wiktorowicz, et al., 2010), and generally refers to the existence of formal policies and procedures which direct organizational processes and organizational relationships. The formalization of inter-organizational
partnerships can be dichotomous (informal versus formal) (Smith et al., 1995; Isett & Provan, 2005),
or considered on a continuum of intensity (e.g., flexible and casual interactions among providers,
non-structured networking, joint planning, care pathway integration) (Nylen, 2007; Dickinson,
2006). From the review of the literature, it does not appear that formalization is conceptualized
differently for dyadic partnerships versus networks. The same principles appear to apply to
networks and dyadic partnerships, while the form or nature of the formalization may look different
(e.g., by definition, networks involve two or more partners).

Formalization can also be used as an organizational characteristic to differentiate types of
governance structures. For example, Wiktorowicz (2010) adopted Whetten’s (1981) framework that
described forms of inter-organizational coordination, and classified network governance structures
into three types: mutual adjustment (based on voluntary exchanges between partnership dyads and
has no formal strategies for coordination); corporate (based on a formal overarching authority that
is responsible for service integration); and alliance (based on autonomous organizations who form a
coalition, where coordination is more formalized than the mutual adjustment structure, but
partners retain their autonomy). Formalization of structures looks different for each of the three
types of governance: mutual adjustment (informal unwritten expectations; no formalization);
alliance (partners develop written expectations); and corporate (central authority develops written
expectations).

Collaboration as a Staff Practice: Administrative & Service Delivery Collaboration

Conceptualizing the inter-organizational partnership process is complex, as we briefly
alluded to previously. Butt et al. (2008) suggest that the salient attributes of partnership processes
fall into four broad themes: 1) agreement of purpose and need for partnership (e.g., recognize and
accept the need to partner; affecting the number and diversity of partners and the frequency of
their interactions); 2) collegial relationships (e.g., reciprocity, communication, trust, respect, equal
status, conflict management; impacts information flow and affects the level of mutual adjustment); 3) interdependency (e.g., sharing, willingness to cooperate, voluntary sharing of resources, flexibility, synergy; a product of collegial relationships); and 4) power and leadership (e.g., shared within the group, based on knowledge and experience, consensual and egalitarian decision-making; emphasize a shared process that occurs through influence versus power).

Collaboration as a staff practice is considered one component of the partnership process and an important factor contributing to partnership functioning (e.g., partnership effectiveness and partnership efficiency). Since 2002, several books/book series (Reeves et al., 2010; Glasby & Dickinson, 2008; Jelphs & Dickinson, 2008; Peck & Dickinson, 2008) and a range of relevant literature reviews have been published examining teamwork and collaboration in health and social care (Oandasan et al., 2006; Lemieux-Charles et al., 2006; Clements et al., 2007; D’Amour et al., 2005; San Martin-Rodriguez et al., 2005; Barrett et al., 2007; Craven & Bland, 2006; Reeves et al., 2010; Jelphs & Dickinson, 2008; HCC, 2009; HPRAC, 2008; Reeves et al., 2011; Xyrichis, A., & Lowton, K., 2008; Zwarenstein et al., 2009; Glasby & Dickinson, 2008).

For the purposes of the current study, we differentiate between two forms of collaboration as a staff practice: administrative collaboration, and service delivery collaboration (see the Glossary for definitions of these terms). We distinguish between these two forms of collaboration as we propose that they fundamentally differ in the key tasks and processes that are experienced and performed by staff members engaged in partnership activities. These differences were evident in the literature review when we compared articles across three fields of inquiry (inter-organizational development, service integration, and collaborative practice). However, very few researchers discuss the differences between administrative and service delivery collaboration (as they are experienced in an inter-organizational context). Table 7 presents the two forms of collaboration and highlights some of the main differences we observed in the literature.
### Table 7: Comparison of Administrative Collaboration & Service Delivery Collaboration

<table>
<thead>
<tr>
<th>Defining Characteristics</th>
<th>Administrative Collaboration</th>
<th>Service Delivery Collaboration</th>
</tr>
</thead>
</table>
|                          | • Occurs at the level of the partnership or administration  
                          | • Service ties target partnership or administrative level (e.g., shared human resources, shared financial resources, governance structure)  | • Occurs at the level of direct patient care  
                          |                          | • Service ties target direct patient care activities (e.g., case coordination, joint consultations, shared programs or services) |

| Examples Tasks & Processes |                          | • Plan together to make decisions about the care for the patients (when appropriate)  
                          |                          | • Communicate openly as decisions are made about patient care  
                          |                          | • Share responsibility for decisions made about patient care  
                          |                          | • Co-operate in making decisions about patient care  
                          |                          | • Consider all professions’ concerns in making decisions about patient care  
                          |                          | • Co-ordinate implementation of a shared plan for patient care  
                          |                          | • Demonstrate trust in one another’s decision-making ability in making shared decisions about patient care  
                          |                          | • Respect one another’s knowledge and skills in making shared decisions about patient care  
                          |                          | • Fully collaborate in making shared decisions about patient care |

*Adapted from the CPQ (Baggs, 1994; Way et al., 2001)

| Staff Perspectives | All staff members are knowledgeable about the partnership and its activities. May include administrators, service providers, and staff members who have dual roles. | All staff members are knowledgeable about the partnership and its activities, and provide direct patient care. May include service providers and administrators who also provide direct patient care (i.e., dual role). |

We acknowledge the ongoing dialogue and efforts to enhance the conceptual clarity of key terms within and across the three fields of scientific inquiry related to this study. We have not
attempted to provide an exhaustive review or discussion of these issues in the current study, and
have focused on differentiating administrative collaboration from service delivery collaboration. We
did not focus on differentiating different terms used to describe administrative collaboration (e.g.,
inter-agency collaboration), or the variety of terms used to describe service delivery collaboration
(e.g., inter- and intra-professional collaboration; inter-, multi- and trans-disciplinary;
interprofessional care). Although it was not an objective of the current study, there is an
opportunity to build upon the recent work of others who have focused on conceptual clarity (e.g.,
Suter et al., 2007; Provan et al., 2007; Reeves et al., 2011; Reeves et al., 2010; Jelphs & Dickinson,
2008), providing direction for future research that spans these three fields of inquiry.

Measurement
Two literature reviews provide an overview of relevant measurement tools, as they relate to
the current study (Granner & Sharpe, 2004; Butt et al., 2008). In a review of partnership
measurement tools, Granner and Sharpe (2004) identified six studies that have measured the
formalization of organizational partnership structures (Kegler et al., 1998; Taylor-Powell et al., 1998;
Gottlieb et al., 1993; Rogers et al., 1993; Florin et al., 2000; and Goldstein, 1997). Limitations of the
measures were significant, given the absence (e.g., not reported or completed) of evidence for
reliability and validity for all but one of the measures (i.e., see Rogers et al., 1993). Conceptually,
formalization was often unclear and undefined, and characterized by a variety of organizational
partnership structures or processes (e.g., existence of: operational systems, mission statements,
agendas/meeting minutes, bylaws, rules, procedures, written objectives, communication/decision-
making procedures).

Butt et al. (2008) reviewed 171 measurement tools relevant to inter-organizational
partnership processes. Using stringent selection criteria, including alignment with their newly
developed conceptual framework for partnerships, the authors narrowed their evaluation activities
to two measurement tools: the Partnership Self-Assessment Tool (PSAT; Weis et al., 2002), and the Team Climate Inventory (Anderson & West, 1994). In the article, these two tools are meticulously compared with one another and against the proposed conceptual framework. The authors conclude that both tools are appropriate for health and social service partnerships.

The majority of tools that are currently available to measure service delivery collaboration are designed for collaboration between specific groups of service providers (i.e., between physicians and nurses, or pharmacists or psychiatrists) and within an intra-organizational context (see Reeves et al., 2010). Few studies provide relevant measurement tools (Sicotte et al., 2002; Smith & Mogro-Wilson, 2007; Smith & Mogro-Wilson, 2008). Sicotte et al. validated a posteriori the concept of interdisciplinary collaboration using two scales (care sharing activities and interdisciplinary coordination). The main limitation of the approach was that the surveys were administered to program coordinators, and did not target those who provide direct patient care. A strength of the tool developed by Smith and Mogro-Wilson (2007) was its applicability to an inter-organizational context; its limitation was the narrow populations focus (child welfare and substance abuse).

**Empirical Support for the Association Between Formalization and Collaboration**

We have presented the theoretical foundation describing a variety of situations under which organizations might form IORs, why they might formalize IORs, and why formalization might be associated with collaboration. We now turn to the empirical literature to explore what evidence exists to support an association between formalization and collaboration as a staff practice (see Table 8 for a review of the main studies).
<table>
<thead>
<tr>
<th>Article</th>
<th>Objective</th>
<th>Theory or Conceptual Framework (CF)</th>
<th>Population</th>
<th>Methods &amp; Measurement Tools</th>
<th>Results Specific to Formalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kegler et al (1998)</td>
<td>Identify factors that contribute to the effectiveness of community health promotion coalitions</td>
<td>CF adapted from Florin et al. (1993)</td>
<td>10 coalitions</td>
<td>Formalization score constructed by giving 1 point each for bylaws, written agendas, written minutes.</td>
<td>Resource mobilization (+) (.66, p&lt;0.05); extent of partnership plan implemented (+) (.57*, p&lt;0.01); number of activities implemented (ns); member participation (ns); member satisfaction (ns)</td>
</tr>
<tr>
<td>Rogers et al. (1993)</td>
<td>To understand coalition development and functioning</td>
<td>CF developed</td>
<td>361 coalition members and staff (representing 61 coalitions)</td>
<td>Developed 8 item scale (y/n) to measure formalized rules and procedures (alpha=0.72) Correlational &amp; stepwise, multi-linear regression</td>
<td>Member organization commitment (+) (0.38**, p&lt;0.01); staff perceptions of outcome efficacy (ns); Member perceptions of outcome efficacy (ns); staff satisfaction with the coalition (+) (0.40, p&lt;0.01); Member satisfaction with the coalition (ns)</td>
</tr>
<tr>
<td>Florin et al. (2000)</td>
<td>See if initial development predicted intermediate outcomes 1yr later</td>
<td>Adapted from Florin et al. (1992)</td>
<td>35 substance abuse coalitions</td>
<td>Count of 11 different dimensions of formalized rules and procedures Correlational</td>
<td>Partnership plan quality (ns); scope of strategies (ns); implementation effects (ns)</td>
</tr>
<tr>
<td>Sicotte et al. (2002)</td>
<td>Measure intensity of collaboration and identify organizational and professional factors that impact collaboration</td>
<td>CF developed (organizational theory; contingency theory)</td>
<td>150 Community Health Care Centres; 4 programs</td>
<td>Regression</td>
<td>Coordination mechanisms (+); (+) interdisciplinary coordination; (+) interdisciplinary care sharing activities</td>
</tr>
<tr>
<td>Wiktorowicz et al. (2010)</td>
<td>Clarify governance process that foster inter-organizational collaboration and supporting conditions</td>
<td>Adapted work of Whetten (1981); org theory</td>
<td>10 MH Networks</td>
<td>Case study; Qualitative: document reviews, interviews, focus groups (secondary analysis of Fleury et al., 2004)</td>
<td>(+) inter-organizational coordination/ cooperation/collaboration</td>
</tr>
<tr>
<td>Fleury (2005)</td>
<td>Develop and present 4 models of MH integrated networks</td>
<td>CF developed</td>
<td>Secondary analysis of MH network case studies</td>
<td>Based on secondary analysis of previous case study research</td>
<td>(+) more enduring coordination</td>
</tr>
<tr>
<td>Article</td>
<td>Objective</td>
<td>Theory or Conceptual Framework (CF)</td>
<td>Population</td>
<td>Methods &amp; Measurement Tools</td>
<td>Results Specific to Formalization</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
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<td>-----------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Smith &amp; Mogro-Wilson (2007)</td>
<td>To identify organizational conditions and staff characteristics that impact inter-organizational collaboration</td>
<td>CF developed (no explicit theory mentioned)</td>
<td>Child welfare and substance abuse treatment agencies</td>
<td>Correlational, multi-level regression</td>
<td>Formalization (organizational culture): routinization (0.18, p&lt;0.05) and hierarchy (0.44, p&lt;0.01). Formalization of organizational policies: knowledge/skills related to inter-agency collaboration (-.18, p&lt;.05); reports of role overload (0.27, p&lt;.01); organizational climate (0.20, p&lt;0.05). Formalization (organizational culture): expectancies (-.15, p&lt;.05), emotional exhaustion (0.19, p&lt;0.01), role overload (0.27, p&lt;0.01), organizational climate (0.25, p&lt;0.01)</td>
</tr>
<tr>
<td>Smith &amp; Mogro-Wilson (2008)</td>
<td>To address the practice of inter-agency collaboration and assess how it varies within and between organizations</td>
<td>CF not explicit</td>
<td>Administrators and front line staff in child welfare and substance abuse agencies.</td>
<td>Multi-level regressions</td>
<td>Staff perceptions of policy toward collaboration are a stronger predictor of collaborative practice than are administrator reports of agency policy toward collaboration.</td>
</tr>
<tr>
<td>Polivka et al. (2001)</td>
<td>--</td>
<td>CF developed</td>
<td>Rural early intervention collaboratives</td>
<td>Developed the 18-item Inter-agency collaboration assessment tool (ICAT) Path analysis</td>
<td>Formalization was excluded from the analysis and no data linking formalization with inter-agency collaboration was provided.</td>
</tr>
</tbody>
</table>

Terms: (ns) not significant; (CF) conceptual framework; (MH) mental health. Relationships are reported ‘as is’, directly from the empirical studies.
Formalization and Administrative Collaboration

As mentioned previously, there is general acceptance of the value of formalized inter-organizational structures. Few studies have tested the impact of formalization on administrative collaboration, and most have used a case study or comparative analysis approach to understanding how administrative collaboration works, and the impact of formalization, and most have examined IORs in a multi-partner context (versus partnership or dyad).

The model for governance and management of community health partnerships developed by Mitchell and Shortell (2000) identified governance and management dimensions that could be impacted by formalization. The dimensions of governance that they propose impact partnership effectiveness include: determining purpose and scope; setting strategic direction; choosing size and composition; determining resource levels and procurement; choosing governance structures for coordination and integration; and establishing accountability parameters. These are potential factors that are influenced by formalization activities. Dimensions of management included: creating a shared vision/mission; engaging and maintaining member interest; implementation (organizational structures, coordination, integration); management (communication channels, conflict, external links, change over time); and monitoring (progress, evaluation and accountability). These are potential roles and responsibilities of management or administrators, and could be influenced by formalization. The model did not include service delivery dimensions.

D’Amour et al. (2004) conducted a comparative study of inter-organizational partnerships in four Quebec (Canada) health regions that provide perinatal services. The authors divide the process of collaboration (i.e., administrative collaboration) into four components: delegation of authority (e.g., centrality, leadership, expertise, connectivity); finalization (e.g., goals, objectives, allegiances); sense of belonging (mutual acquaintanceship, trust); and formalization (agreements/rules, information infrastructure). Using a multiple case study research design, the authors identified
three types of partnerships (collaboration in action, collaboration under construction, and collaboration inertia) and described how the four components were characterized in each of the types of partnerships. *Collaboration in action* was characterized as the highest level of collaboration (e.g., shared and consensual leadership, consensual agreement, jointly defined rules, regular meetings or interactions, grounded trust). *Collaboration under construction* was characterized as the mid level of collaboration (e.g., fragmented leadership, non-consensual agreement, fragmented interactions, contingent trust). *Collaboration in inertia* was characterized as the lowest form of collaboration (e.g., monopolized leadership, no agreement or not respected, little interaction or meeting, lack of trust). The results of the study by D’Amour et al. (2004) suggested that formalization was strongest in the first two types (e.g., consensual agreement, jointly defined rules, data collection and sharing mechanisms), but weak in collaboration inertia (e.g., no agreements or it was not respected or was a source of conflict; little or no shared data collection infrastructure or mechanism). Thus, partnerships that were more formalized were also perceived to have higher functioning relationships related to collaboration.

Fleury (2005) conducted a secondary analysis of mental health case study networks in Quebec (Canada), and developed four models of mental health integrated networks (i.e., two rural models, an urban or semi-urban model, and a metropolitan model). The results of the study suggested that formalizing inter-organizational activities, particularly by reinforcing governance mechanisms at a local level, was a strategy that could be used to permit more enduring coordination among the partnering organizations. Formalization activities influence the organization and implementation of integration efforts.

Wiktorowicz (2010) conducted a comparative analysis of 10 mental health networks, and examined the role of formalization within three different types of governance structures (i.e., mutual adjustment, corporate, and alliance). The results of the study suggested that administrative
collaboration (sometimes referred to by the authors as inter-organizational coordination, cooperation or collaboration) was more advanced in the corporate governance structure (where formalization is highest).

Overall, it would appear that there is preliminary support for the positive impact of formalized inter-organizational structures on administrative collaboration. A challenge with generalizing the results of the above studies to the current research study has to do with the focus on case study networks versus partnership dyads. The case study approach provides insights at a broad level, helping to identify general models of administrative collaboration and findings related to the impact of formalization. A contribution to further understanding the influence of formalization would be to test the impact directly on administrative collaboration.

**Formalization and Service Delivery Collaboration**

As mentioned previously, there is general acceptance of the value of formalization of inter-organizational structures. Formalization has been identified as a structural characteristic that influences specific service delivery processes (e.g., formalization of care activity procedures, formalization of the assessment of quality of care) (Sicotte et al., 2002). The analytical framework proposed by Sicotte et al. (2002) suggests that formalization may impact a series of key intra-group processes, which in turn influence levels or intensity of interprofessional collaboration. The intra-group processes include aspects such as: belief in the benefits associated with collaboration; social integration within groups; level of conflict resulting from interprofessional collaboration; agreement with disciplinary and interdisciplinary logic; and work group design characteristics (Sicotte et al., 2002). However, the researchers did not provide guidance on how the impact of formalization may differ among service providers who work together across organizational boundaries.

In the review article by San Martin-Rodriguez et al. (2005), the impact of formalization was examined in two studies (D’Amour et al., 1999; Sicotte et al., 2002), and was classified under the
theme ‘coordinating mechanisms’ (as opposed to organizational structure). In both studies, formalization was positively correlated with interprofessional collaboration (noting that these studies did not examine collaboration in an inter-organizational context). The D’Amour et al. (1999) paper was not accessible for review, as it was not available in English. Sicotte et al. (2002) examined the role of formalization in predicting collaboration within Quebec (Canada) community health centres. Their findings suggested that use of formalized administrative processes (e.g., written rules and procedures) was a strategy used to promote collaboration (mean scores ranging from 3.1 to 3.6, of possible 5). Of the contextual variables thought to influence the intensity of collaboration, formalization of the assessment of the quality of care and formalization of care activities demonstrated the highest association (compared to: characteristics of the program manager, size of the professional workforce, and organization budget). However, intra-group process variables explained most of the variance in intensity of collaboration (e.g., beliefs in benefits association with collaboration, social integration within groups, level of conflicts associated with collaboration, agreement with interdisciplinary logic) (where interdisciplinary is assumed to be used interchangeably with interprofessional). Their regression models explained 59% (interdisciplinary coordination) and 72% (interdisciplinary care sharing activities) of the variance in intensity of collaboration. On a 5-point scale, scores of collaboration remained near 3.58-3.89 (lower than expected).

In a separate study showing mixed results, Smith and Mogro-Wilson (2007) examined individual staff level and organizational level factors that influence inter-agency collaboration (i.e., service delivery collaboration). Individual level factors included: beliefs and attitudes about collaboration (intention to collaborate), influences on the intention to collaborate (i.e., normative pressures and expectancies of collaboration), moderators of the relationship between intention to collaborate and collaborative behaviours (i.e., knowledge and skills about collaboration, perceived
advantages and disadvantages of collaboration, and salience of collaboration). *Organizational level factors included:* organizational policies about collaboration (i.e., role overload, emotional exhaustion), and organizational climate (i.e., formalization, hierarchy, routinization). The authors reported that formal organizational arrangements and policies were significantly correlated with two factors relevant to collaboration: knowledge/skills related to inter-agency collaboration (-.18, p<.05) and reports of role overload (0.27, p<.01). Formalization (as a component of organizational culture) was significantly correlated with: expectancies (-.15, p<.05), emotional exhaustion (0.19, p<0.01), role overload (0.27, p<0.01), organizational climate (combination of exhaustion and role overload; 0.25, p<0.01), routinization (0.18, p<0.05) and hierarchy (0.44, p<0.01). Mean scores for collaboration were not provided.

Using a mixed methods case study approach, Nylen (2007) collected data from seven collaborative projects (including partnerships and networks) and identified three strategies for collaboration. Collaboration in this context is assumed at the level of the service provider. The *assignment reallocation strategy* was characterized as collaboration where patients or specific tasks are exchanged between service providers. Intensity of the interaction is low and limited to service coordination, and some degree of formalization is required. The *commitment-based networking strategy* was characterized by mainly informal interactions among staff that jointly provided a new set of services. Personal relationships (especially principles of trust, commitment and reputation) are critical and more important than formalized structures, and collaboration requires a medium to high intensity of interaction. The *formalized teambuilding strategy* was characterized as the most advanced strategy of collaboration, and perceived as necessary during complex interdependencies and with patients with multiple needs (Nylen, 2007). Intensity of interactions and formalization are both high and the strategy may yield the greatest yield of positive outcomes, but at a cost, as this strategy likely requires additional resources and greater risk. Nylen described the impact of
formalization and task intensity on partnership effectiveness, and discovered that effectiveness was influenced by these two factors in differing ways. The results of the study suggested that intense collaborative interactions among staff could substitute for high degrees of formalization in the partnership. Nylen also suggested that high levels of trust among partners could have a similar impact. The author concludes that while formalization shows mixed effects on partnership effectiveness, formalized structures are necessary unless staff members are able to achieve sufficient levels of interaction (intensity) without formalized support.

Overall, the studies suggest there is preliminary support for the association between formalized inter-organizational structures and service delivery collaboration. However, no studies have explicitly looked at the impact of formalized organizational structures on service delivery collaboration.

**Other Factors Associated With Collaboration**

Formalization is not the only organizational structure that could be associated with collaboration. In examining the literature reviews related to administrative and service delivery collaboration, there are at least three categories/themes of factors that have been theoretically or empirically linked with collaboration, including environmental, organizational and interpersonal factors. This study did not attempt to develop a conceptual framework (and corresponding research questions and hypotheses) that is comprehensive of all of the possible factors that might be associated with collaboration. However, they are relevant, and we have provided a brief overview to acknowledge the complexity of inter-organizational partnerships, formalization, and the development of collaborative processes as a staff practice.

Based on previous research (Butt et al., 2008; Lasker et al., 2001; Weiss et al., 2002; Glaasby & Dickinson, 2008), factors that may have an impact on administrative collaboration can be categorized into three broad themes: systemic (e.g., factors external to the organization, such as
environmental or community context); organizational structures (e.g., communication mechanisms); and organizational processes (e.g., leadership effectiveness, partnership efficiency). What appears to be missing in the literature is a category related to interactional or interpersonal factors at the level of the individual group members.

Based on previous research (D’Amour & Oandasan, 2005; San Martin-Rodriguez et al., 2005; Smith & Mogro-Wilson, 2007; Sicotte et al., 2002; Reeves et al., 2010; Xyrichis & Lowton, 2008; HCC, 2009; Reeves et al., 2011), factors that may have an impact on service delivery collaboration can be categorized into three broad themes: factors external to the organization (e.g., systemic or environmental); organizational factors (e.g., structures and processes within the organization such as organizational philosophy or coordination mechanisms); and interactional (i.e., individual characteristics, and processes at work in interpersonal relationships at an individual level).

Summary

Several main themes emerged from the literature review. First, there is a consistent absence of strong theoretical foundations in many of the empirical studies that were reviewed (or in some articles, there was a lack of explicit theoretical perspectives or discussion of how theory informed the research). This is a theme in the literature that has been observed by other researchers (e.g., Dickinson, 2006; Butt et al., 2008). The lack of a strong theoretical basis for empirical work results in a lack of clarity of the underlying assumptions made by researchers in developing their conceptual frameworks or models, and the corresponding research questions and hypotheses. This limits the ability of collaborating researchers who wish to build upon or expand on previous research, and reduces the coherence of a field of inquiry.

Second, bringing together three different fields of inquiry (inter-organizational development, service integration and collaborative practice) yielded many differences and challenges with language and the conceptualization and measurement of the main study variables.
For example, not all authors provided definitions for IOR types such as partnerships, coalitions, alliances, networks, cooperative arrangements, or collaborative agreements and often, the terms are used interchangeably (Provan et al. 2007). In addition, it was particularly challenging to compare different articles measuring collaboration, because some researchers did not differentiate forms of collaboration (e.g., collaboration as an organizational practice versus collaboration as a staff practice). And in some cases, researchers defined or conceptualized a form of collaboration that did not appear to match the form of collaboration that was actually measured. Researchers have highlighted the need to consider these multiple perspectives (Butt et al., 2008; Smith & Mogro-Wilson, 2007; Sicotte et al., 2002), and select appropriate methods and measurement tools.

Third, there were only a few studies that specifically discussed or explored the possible association between formalization and collaboration, and even fewer that brought together both theoretical and empirical research to guide the study. The disconnection between theory and evidence in previous research provides opportunity for investigation for the current study. Finally, the research examining service delivery collaboration in the context of inter-organizational partnerships in health and social services is very limited. Most of the research completed to date examines service delivery collaboration within an intra-organizational context (i.e., groups of service providers who work within the same organization).

Conclusion
The literature review has brought together findings from three fields of inquiry. It has presented the main conceptual frameworks that help us to understand the partnership process, and the conceptualization and measurement of the main variables for the current study, and has provided a summary of the available empirical support for an association between formalization and collaboration. Although the literature review revealed growing empirical support for the association between formalization and collaboration, most studies lack a strong theoretical foundation, and do
not provide an in-depth perspective on the rationale for the association between formalization and collaboration. Most use a case study or comparative analysis approach to categorizing and characterizing different forms of partnerships or networks (and how formalization may be related to levels of collaboration).

The current study provides an opportunity to extend previous research by: integrating three fields of inquiry into one study; building upon a theoretical rationale for the association between formalization and collaboration; and using a mixed methods approach to both testing and explaining the association between formalization and collaboration. The results of the study will help determine if there is an association between formalization and collaboration as a staff practice, and provide insights about how this relationship is experienced by administrators and service providers who participate in inter-organizational partnerships.
Chapter 3: Conceptual Framework & Hypotheses

Researchers have documented both theoretically and empirically a variety of structures and processes that are involved in inter-organizational partnerships (and IORs more broadly). We approached this study with a focus on exploring the distinct relationship between formalization and collaboration. This chapter presents the conceptual framework, research questions and hypotheses that direct the current research study, and reviews the definitions of the study variables.

Overview

This study investigates the association between formal inter-organizational partnerships and two forms of collaboration (administrative and service delivery collaboration), as presented in the conceptual framework used to guide the current study (Figure 3).

Figure 3: Overview of the Basic Conceptual Framework & Hypotheses

```
<table>
<thead>
<tr>
<th>Formalization of Inter-Organizational Partnerships</th>
<th>H1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administrative Collaboration</td>
</tr>
<tr>
<td></td>
<td>H2</td>
</tr>
<tr>
<td></td>
<td>Service Delivery Collaboration</td>
</tr>
<tr>
<td></td>
<td>Partnership Effectiveness &amp; Efficiency</td>
</tr>
</tbody>
</table>
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Note: *Dashed lines represent relationships and variables not measured in the current study.

Building upon the conceptual framework, four primary research questions and two hypotheses were developed to address gaps identified in previous research. Four additional
secondary research questions were also developed. For the current study, the formalization of interorganizational partnerships is the independent variable, and administrative collaboration and service delivery collaboration are the two dependent variables.

**Administrative Collaboration:**

1 a) Do staff members engaged in formal inter-organizational partnerships report higher levels of administrative collaboration?

H1: Staff members in formalized inter-organizational partnerships will report higher levels of administrative collaboration, compared to those in informal inter-organizational partnerships.

Secondary research questions (exploratory):

1 b) Does the relationship between formalization and administrative collaboration vary by organizational type?

1 c) Does the relationship between formalization and administrative collaboration vary by staff role?

2) How is administrative collaboration experienced by administrators who participate in formal versus informal partnerships?

**Service Delivery Collaboration:**

3 a) Do staff members engaged in formal inter-organizational partnerships report higher levels of service delivery collaboration?

H2: Staff members who provide direct patient care in formalized inter-organizational partnerships will report higher levels of service delivery collaboration, compared to those in informal inter-organizational partnerships.
Secondary research questions (exploratory):

3 b) Does the relationship between formalization and service delivery collaboration vary by organizational type?

3 c) Does the relationship between formalization and service delivery collaboration vary by staff role?

4) How is service delivery collaboration experienced by service providers who participate in formal versus informal partnerships?

Research questions 2 and 4 are descriptive in nature and were addressed using qualitative methods (telephone interviews), and thus do not have corresponding hypotheses. The current study did not examine the relationship between administrative collaboration and service delivery collaboration, or the relationships between collaboration and partnership effectiveness and efficiency.

**Independent variable**

As previously discussed, the independent variable selected for this research came from the conceptualization of inter-organizational partnerships through the lens of a structure-process-outcome model.

**Formalization**

Vlaar et al. (2007b) define formalizations as “the process of codifying and enforcing output and/or behaviour, and its outcomes in the form of contracts, rules and procedures” (p. 439). We have classified the formalization of inter-organizational partnerships as an outcome of the formalization process, resulting in an organizational structure. We use a dichotomous, categorical definition of formalization, whereby a partnership either has a formal or informal partnership structure. The rationale for selecting a dichotomous definition was similar to the rationale proposed
by Isett and Provan (2005), who suggest that a contractual tie (written agreement) is a legally enforceable statement about the relationship between two partners.

We specifically looked at whether or not two organizations (partnership dyad) shared at least one type of a formal inter-organizational agreement (i.e., a formal partnership). Examples of formal agreements included: partnership agreements; memorandum of understanding; affiliation agreements; service agreements; secondment agreements; and strategic alliance agreements; bylaws; and written policies/procedures. A partnership was considered ‘informal’ if it lacked an inter-organizational agreement.

**Dependent variables**

- Collaboration as a staff practice is: 1) conceptualized within a structure-process-outcome model; 2) conceptualized as existing within an inter-organizational partnership context (i.e., type of IOR); and 3) part of the inter-organizational partnership process.

**Administrative Collaboration**

Administrative collaboration is defined as the combining of the perspectives, knowledge, and skills of diverse partners in a way that allows the partnerships to: “1) think in new and better ways about how it can achieve its goals; 2) plan more comprehensive, integrated programs; and 3) strengthen its relationship to the broader community” (Lasker et al., 2001; Weiss et al., 2002, p. 684). Administrative collaboration occurs between two or more individuals who engage in administrative tasks related to the planning, implementation or evaluation of partnership activities. Activities may vary, but do not involve direct patient care.

**Service Delivery Collaboration**

- We define service delivery collaboration as “an interprofessional process for communication and decision-making that through the practice of core collaborator competencies, enables the knowledge and skills of care providers from different types of organizations to synergistically
influence the patient care provided”. Service delivery collaboration occurs between two or more individuals who engage in the direct delivery of patient care. These staff members may be service providers, or administrators who have dual roles and also provide direct patient care.

We developed a definition by bringing together previous definitions of inter-agency collaboration (found in the integration literature) and definitions of collaborative practice, interprofessional care, and interprofessional collaboration (found in the collaborative practice literature). We were specific in this approach for several reasons. Service delivery collaboration does not simply involve the sharing of knowledge, skills or information across organizations, between staff members (partners). It is also about the quality of these exchanges, specifically as they influence the quality of patient care, and we wanted to incorporate core collaborator competencies as part of the definition.

We provide the relevant definitions as a way of summarizing previous work. Inter-agency collaborative practice (at the service delivery level) is defined as the “exchange of information or resources among staff members from different types of agencies” (Smith et al., 2007, p. 546). Collaborative practice is defined as an “interprofessional process for communication and decision-making that enables the knowledge and skills of care providers to synergistically influence the client/patient care provided” (Way & Jones, 2000, p. 3). Interprofessional collaboration is defined as “a process that requires relationships and interactions between health professionals regardless of whether or not they perceive themselves as part of a team” (Oandasan et al., 2006, p. 4). The core competencies of interprofessional collaboration include: knowledge of healthcare professional roles; ability to communicate effectively with other health professionals; ability to reflect the effect of health professionals’ roles and attitudes related to mutual trust; and willingness to collaborate (Oandasan et al., 2006).
Chapter 4: Overview of Methods

In this chapter we provide an overview of the methods used in the current study. We begin with the rationale for selecting a mixed methods approach, followed by a high level overview of the study, its three phases, and study participants. We then review each phase of the study in more detail, including objectives, sampling methods and selection criteria, measurement tools, methods, data collection, approach to the analysis, and ethical considerations.

As mentioned, the current research study was part of a much larger research project conducted through the University of Toronto. We limit the discussion of the methods and analysis to the dissertation component of the larger research project. However, in the appendices containing the surveys and interview guides, we have provided these documents in full, rather than removing sections that are not relevant to the current study.

The Rationale for a Mixed Methods Study

Building upon nearly 30 years of debate and discussion (Tashakkori & Creswell, 2007) researchers have increasingly identified the value and need for mixed methods research to complement the more traditional quantitative and qualitative approaches to scientific inquiry (Creswell, 2003). Mixed methods has been broadly defined as “research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or a program of inquiry” (Tashakkori & Creswell, 2007, p. 4). The proliferation of resources available to guide mixed methods research are available in a range of books and journals (lists of relevant resources can be found in: Tashakkori & Creswell, 2007; Creswell, 2003), and cross many diverse disciplines. Evidence that scientific inquiry supports mixed methods research is also evident in the increased number of related funded projects and research programs.
An expressed limitation of previous studies that have examined IORs has been that the data collection techniques have been insufficient in providing enough depth or richness in understanding the complex nature of these relationships. Inter-organizational partnerships are complex and data must be collected in a variety of ways (e.g., closed ended and open ended questions), from a variety of perspectives (e.g., administrative and front line service providers). Researchers have indicated the need for future research to use mixed methods approaches to better understand why and how partnerships and collaboration occur among actors in the health care system (Ansari & Weiss, 2006; Strandberg-Larsen et al., 2009; Browne, et al. 2007; Butt et al., 2008).

We used Creswell’s four criteria for selecting a mixed methods strategy (Creswell, 2003): 1) What is the implementation sequence of the quantitative data collection in the proposed study?; 2) What priority will be given to the quantitative and qualitative data collection and analysis?; 3) At what stage in the research project will the quantitative and qualitative data and findings be integrated?; And 4) Will an overall theoretical perspective be used in the study?

**Study Overview**

The research study was guided by the conceptual framework presented in Chapter 3, which informed the research questions, hypotheses, study design, data collection tools/methods, analysis and integration of the qualitative and quantitative findings. The study used a sequential quantitative-qualitative mixed methods design, with three distinct data collection Phases.

The objective of Phase I was to describe the current inter-organizational partnerships that existing FHTs and CHCs have (formally or informally) with their community MHA organization partners. The objective of Phase II was to determine if formalization of inter-organizational partnership structures is associated with the level of administrative collaboration and/or level of service delivery collaboration. The objective of Phase III of the study was to explore how aspects of
administrative collaboration and service delivery collaboration are experienced by the staff members who work in formal and informal partnerships.

For efficiency reasons and to minimize time between data collection points, the Phases overlapped. However, for the purposes of data analysis, interpretation of findings and integration of the qualitative and quantitative findings, the three Phases of the study could have been completed entirely sequentially, since the integration of data sets for Phase II and III occurred during data analysis and writing of the dissertation. See Table 9 for an overview of the main activities for the study.

Table 9: Overview of Phases I, II & III Main Activities

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<td>Participant Recruitment</td>
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<td>Data Analysis (to identify participants for Phase III)</td>
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<td>Phase III (qualitative)</td>
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<td>Participant Recruitment</td>
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<td>Writing of Thesis</td>
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Note: (X) indicates a period of activity during the Phase of the study.

Consent for participation in the three Phases of the study was obtained at two levels: the executive director (ED) (or equivalent) and the individual staff members (unique criteria for each Phase of the study). The ED (or equivalent) provided consent for the organization’s participation in the entire study and helped to identify a) a main contact for the organization, and/or b) individual staff members eligible for participation in one or more phases of the study. An overview of eligibility criteria and consent is provided in Table 10.
The study employed a six step sampling strategy, in order to identify the most appropriate participants (individual staff members of selected eligible organizational partnerships), while reducing response burden and potential confusion for study participants. Each Phase built upon the previous Phase in terms of sampling. Data collection methods included online surveys and semi-structured interviews, and participants included administrators and service providers of FHTs, CHCs and MHA organizations in the province of Ontario, Canada. An overview of the sampling strategy and participation is provided in Table 11. See Figure 4 for a diagram summarizing the Phase I, II and III design and methods.
Table 10: Overview of Eligibility & Consent

<table>
<thead>
<tr>
<th>Study Phase</th>
<th>Eligibility &amp; Selection Criteria</th>
<th>Consent</th>
<th>Target Participant</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I</td>
<td>Organization Eligibility Criteria: All FHTs and CHCs in operation as of September 2009 were eligible to participate in the study. Participant Eligibility Criteria: A knowledgeable person was defined as “the individual most knowledgeable about the organization’s inter-organizational partnership policies and procedures”.</td>
<td>Consent obtained at two levels. First, consent was obtained from the ED or equivalent from each organization. Consent for organizational participation in Phase II and III was obtained from the FHTs and CHCs who agreed to participate in Phase I.</td>
<td>One eligible participant from each FHTs and CHCs.</td>
<td>Online Survey</td>
</tr>
<tr>
<td>Phase II</td>
<td>Eligible partnerships between FHTs, CHCs and their MHA organizational partners were identified in Phase I. Partnership Inclusion Criteria: the organizational partnership has existed for a minimum of 6 months; the organizational partnership is with a registered MHA service agency or program; the organization has demonstrated a focus on MHA; and informed consent was provided from the organization’s ED (or equivalent). Partnerships with individual clinicians (e.g., psychiatrists) who are not part of a larger organization were excluded. Eligible organizational partnerships were then randomly assigned to one of 8 groups. From those organizations that agreed to participate, all individuals considered knowledgeable about the partnership were eligible to participate. Participant Eligibility Criteria: Administrative Collaboration: “someone who is familiar with the work of the partnership, as well as its leadership, administration, resources, decision-making processes, and the challenges it faces” (Weiss et al., 2002, p. 686). Service Delivery Collaboration: an individual who interacts with the partner organization to provide services directly to adults seeking access to services across primary care, mental health and addiction organizations.</td>
<td>Consent obtained at two levels. First, consent from the ED or equivalent from each organization was obtained. Second, from each individual staff member who completed the survey.</td>
<td>All eligible administrators &amp; service providers from selected FHTs, CHCs and MHA organizations.</td>
<td>Online Survey</td>
</tr>
<tr>
<td>Phase III</td>
<td>Participants from Phase II were eligible to participate in Phase III. Sampling of the interview participants was purposeful so that selected participants spanned the following characteristics: type of organization (FHT, CHC and MHA), formalized ‘yes’/‘no’ partnerships, role (administrator, service provider), and gender.</td>
<td>Consent obtained at two levels. First, consent from the ED or equivalent from each organization was obtained in Phase I. Second, from each individual staff member who participated in an interview.</td>
<td>Purposeful sample of administrators &amp; service providers from Phase II.</td>
<td>Phone Interview</td>
</tr>
</tbody>
</table>

Note: FHT (Family Health Teams); CHC (Community Health Centres); MHA (mental health and/or addictions organizations); ED (Executive Director).
### Table 11: Overview of Sampling Strategy & Participation

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Total (N)</th>
<th>FHT</th>
<th>CHC</th>
<th>All MHA (MHA-FHT &amp; MHA-CHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Phase I MHA Partnerships</td>
<td>210 total organizations (139 FHTs &amp; 71 CHCs)</td>
<td>97 FHTs organizations total (69.8% response rate)</td>
<td>54 CHCs organizations total (76.0% response rate)</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Identify all FHT and CHC partnerships with MHA organizations, and shared focus on adults with MHA needs</td>
<td>567 organizations total (269+190+69+39)</td>
<td>69 FHT-MHA organizations total (i.e., only 69 of 97 FHTs had MHA partnerships)</td>
<td>31 CHC-MHA organizations total (i.e., only 39 of 54 CHCs had MHA partnerships)</td>
<td>269 MHA-FHT organizations total (F: 13)</td>
</tr>
<tr>
<td></td>
<td>Phase II Sample (completed info)</td>
<td>389 total eligible partnerships (53+31+182+123)</td>
<td>53 FHTs organizations total (F: 8 FHT-MHA partners)</td>
<td>31 CHC-MHA organizations total (F: 16 CHC-MHA partners)</td>
<td>126 MHA-FHT organizations total (F: 23 MHA-FHT partners)</td>
</tr>
<tr>
<td>2</td>
<td>Phase II Eligible</td>
<td>151 organizations responded (71.9% response rate overall)</td>
<td>39 CHC-MHA organizations total (i.e., only 39 of 54 CHCs had MHA partnerships)</td>
<td>200 CHC-MHA organizations total</td>
<td>190 MHA-CHC organizations total (F: 46)</td>
</tr>
<tr>
<td></td>
<td>Determine sampling frame for organizational partnerships.</td>
<td>513 MHA partnerships total</td>
<td>31 CHC-MHA organizations total (F: 16 CHC-MHA partners)</td>
<td>200 CHC-MHA organizations total</td>
<td>190 MHA-CHC organizations total</td>
</tr>
<tr>
<td>3</td>
<td>Phase II Invited (actual)</td>
<td>157 actual selected partnerships (33+24+62+38)</td>
<td>33 FHTs organizations total (F: 7 FHT-MHA partners)</td>
<td>24 CHC-MHA organizations total (F: 15 CHC-MHA partners)</td>
<td>182 MHA-FHT organizations total (F: 12 MHA-FHT partners)</td>
</tr>
<tr>
<td></td>
<td>Determine eligible partnerships based on criteria.</td>
<td>425 eligible participants</td>
<td>92 Eligible partners total</td>
<td>59 Eligible participants total</td>
<td>182 MHA-FHT organizations total (F: 12 MHA-FHT partners)</td>
</tr>
<tr>
<td>4</td>
<td>Phase II participants (actual)</td>
<td>157 actual selected partnerships (33+24+62+38)</td>
<td>33 FHTs organizations total (F: 7 FHT-MHA partners)</td>
<td>24 CHC-MHA organizations total (F: 15 CHC-MHA partners)</td>
<td>182 MHA-FHT organizations total (F: 12 MHA-FHT partners)</td>
</tr>
<tr>
<td></td>
<td>Select eligible organizations to confirm participation and identify all eligible staff. Organizations that declined to participate or did not respond were excluded.</td>
<td>425 eligible participants</td>
<td>92 Eligible participants total</td>
<td>59 Eligible participants total</td>
<td>182 MHA-FHT organizations total (F: 12 MHA-FHT partners)</td>
</tr>
<tr>
<td>5</td>
<td>Phase III Participants (actual)</td>
<td>Contact all eligible staff and gather individual consent.</td>
<td>258 actual participants total (F: 90 individuals)</td>
<td>44 actual CHC participants (F: 24 individuals)</td>
<td>151 actual MHA participants (F: 48 individuals)</td>
</tr>
<tr>
<td></td>
<td>Select eligible individuals for interviews.</td>
<td>258 actual participants total (F: 90 individuals)</td>
<td>44 actual CHC participants (F: 24 individuals)</td>
<td>44 actual CHC participants (F: 24 individuals)</td>
<td>151 actual MHA participants (F: 48 individuals)</td>
</tr>
<tr>
<td>6</td>
<td>Phase III Participants</td>
<td>20 individuals total</td>
<td>20 individuals total</td>
<td>20 individuals total</td>
<td>20 individuals total</td>
</tr>
</tbody>
</table>

Note: FHT (Family Health Teams); CHC (Community Health Centres); MHA (mental health and/or addictions organizations); F (formal partnership); I (informal partnership)
Figure 4: Overview of the Study Design & Methods

Phase I (Quantitative)

- All FHTs (n=139) & CHCs (n=71) sent Phase I survey
- Phase I surveys collected & eligible partnerships identified for Phase II
- Random selection of all eligible partnerships into 4 categories and 8 groups

Phase II (Quantitative)

- Phase II participants sent survey (n=425)
- Phase II surveys collected (n=258) & selection of participants for Phase III

Phase III (Qualitative)

- FHTs (n=5)
  - Formal: Admin (2), Provider (2)
  - Informal: Admin (0), Provider (1)

- CHCs (n=5)
  - Formal: Admin (2), Provider (1)
  - Informal: Admin (1), Provider (1)

- MHAs (n=10) (MHA-FHT + MHA-CHC)
  - Formal: Admin (3), Provider (1)
  - Informal: Admin (1), Provider (5)
Phase I: Environmental Scan of Ontario FHT & CHC Partnerships with MHA Organizations

Phase I: Objective

The objective of Phase I was to describe the current inter-organizational partnerships that existing FHTs and CHCs have formally or informally with their community MHA organization partners.

Phase I: Sample & Eligibility

As of September 2009, 139 FHTs and 71 CHCs were in operation and eligible for inclusion in Phase I of the study. A list of FHTs was obtained online through the MOHLTC, and a list of CHCs was obtained online through the AOHC.

An online survey was developed using “Survey Monkey”, to collect basic information about the current inter-organizational partnerships between FHTs and their MHA organizational partners, and CHCs and their MHA organizational partners. Data was not collected directly from MHA organizations during Phase I, as it was thought that this would lead to unnecessary duplication of information and increased response burden for the participants.

Consent for the FHT or CHC organization’s participation in the three Phases of the study was obtained from the ED (or equivalent) during Phase I, by a trained research associate (RA). During a scheduled phone meeting, the RA provided an overview of the study. The consent allowed researchers to contact members of the organization to identify potential participants for Phases I, II and III of the study, using defined eligibility criteria (unique for each Phase of the study).

For Phase I, the individual considered to be a ‘knowledgeable person’ was defined as “the individual most knowledgeable about the organization’s inter-organizational partnership policies and procedures”. The RA identified the eligible participant(s) with guidance from the ED (or equivalent), and obtained required contact information (phone and email). Only one individual from each FHT or CHC organization was asked to complete the Phase I survey. If more than one individual
met the eligibility criteria, the first available individual was invited to participate. Each FHT and CHC that participated in Phase I was given a unique organizational code. The name of the participant who completed the survey never appeared with the survey code, except in a master file that was kept in a protected document and separate from the data collected to preserve confidentiality.

**Phase I: Survey**

The RA contacted the eligible participant(s) by phone, explained Phase I of the study and obtained informed verbal consent for his/her participation. At this time, participants were provided the option to complete the Phase I survey over the phone; however, no one opted to do this. Once verbal consent was obtained, one participant from each FHT and CHC was sent an email with the following information: an information letter, confirmation that the organization’s participation was consented by the ED (or equivalent), a unique participation code, and a link to complete the Phase I online survey.

The self-report questionnaire was piloted with a small representative sample of participants. The survey contained 34 questions, and took approximately 20-30 minutes to complete. Email reminders were sent out at days 5 and 10 (unless otherwise agreed upon with participants), with a maximum of 4 reminders sent to participants. A copy of the survey is provided in the appendix (Appendix A: Phase I Survey).

The survey included four main sections: *participant demographics* (position title, years in current position, age, gender, education); *organizational characteristics* (LHIN region, operating budget, year established, governance model, and population focus on mental health or addictions); and *inter-organizational partnerships* (number, length and activity level of partnerships; formalization; administrative service ties; service delivery ties). Data were collected between September 2009 and March 2010.
An appropriate measure, demonstrating acceptable psychometric properties, to evaluate the formalization of inter-organizational partnerships was not identified in the literature review. Many existing tools assess formalization on a continuum (i.e., based on whether or not a series of organizational processes exist, as described previously). The current study assessed formalization as ‘yes or no’, based on the existence of a formal written agreement shared between the two partnering organizations. Examples of formal written agreements included: partnership agreements; memorandum of understanding; affiliation agreements; service agreements; secondment agreements; and strategic alliance agreements; bylaws; and written policies/procedures.

Phase I: Data Analysis Methods
For the data, descriptive statistics were calculated to characterize the respondents and the study population (inter-organizational partnerships). Means, standard deviation, and minimum/maximum scores (range) are reported as appropriate. Sub-group comparisons for FHTs and CHCs were conducted.

Phase II: The Association between Formalization & Collaboration
Phase II: Objective
The objective of Phase II was to determine if formalization of inter-organizational partnership structures is associated with administrative collaboration and/or service delivery collaboration.

Phase II: Sample
Estimating Response Rates
The independent variable was formalization of partnership structures, which was categorized as formal versus informal. The outcome measures (dependent variables) of this study were administrative collaboration and service delivery collaboration. To estimate how many FHTs, CHCs and MHA organizations were likely to participate, we examined previous studies with similar populations. For example, Weiss et al. (2002) examined inter-organizational partnerships. Of the 71
identified partnerships, 66 agreed to participate (92%) (these were partnerships with 10 agencies per partnership). In another example, Sicotte et al. (2002) examined interdisciplinary collaboration within Quebec community health care centres (CHCCs). They had a response rate of 62% (of 157 CHCCs, they identified 554 programs, and 343 programs participated), but did not report how many CHCCs in total were involved. We estimated a 60% organizational participation rate.

To estimate how many individuals were likely to participate from each organization, we examined relevant literature. For example, Weiss et al. (2002) administered their Partnership Self-Assessment Tool (PSAT) to assess partnership quality. In their sample, they identified an average of 17 potential respondents per partnership (range of 8-39). The partnership included a minimum of five organizations; the authors did not report the number of eligible participants per organization within the partnerships. Using the Collaborative Practice Questionnaire (CPQ) to assess interprofessional collaboration between family physicians and nurse practitioners, Way and Jones (2001) reported a range of response rates of 47% (physicians) and 59% (nurse practitioners). We estimated a similar 60% participation rate.

**Sample Size**

We calculated the sample size in order to have 80% power to be able to detect differences of size greater or equal to half of standard deviation of the primary outcomes. We anticipated using the Generalized Estimation Equation method to compare the averages of the primary outcomes between the two levels of formalizations. The method of generalized estimating equations (GEE) is a generalization of Generalized Linear Models that takes into account the within-group correlation (e.g., the degree to which the responses are correlated among participants from each organization) (Ghisletta & Spini, 2004). Unfortunately the within-group correlation was unknown, based on a lack of previous research reported. Therefore, we assumed independent observations and calculated the sample size, and then inflated it by 25% to account for the possible within-group correlation.
To estimate the sample size, the GEE method was reduced to two sample independent t-tests when the level of formalization is categorized as formal or informal. Assuming 5% type I error and 80% power, the required sample size for detecting a small change (half of one standard deviation) was 64 participants in each group (formal versus informal). In order to account for the within-group correlations, we inflated these sample sizes by 25%. Thus, the required sample size per group was 80 participants. Assuming a 60% response rate and 10% for incomplete data, we needed to approach 165 participants from FHTs, CHCs, and MHA organizations in the ‘yes’ formalization category and 165 in the ‘no’ formalization category (330 individuals total). We conservatively estimated 5 eligible respondents per organization (Weiss et al., 2002), approximately 11 organizations with ‘yes’ formalization category and 11 organizations with ‘no’ formalization category, from FHTs, CHCs and MHA organizations were required (i.e., 55 individuals from each of the six groups; or approximately 66 organizations in total). We estimated a total of 440 possible health provider organizations (139 FHTs, 71 CHCs, and 230 MHA organizations).

**Sampling Approach**

The results of Phase I informed the selection of the inter-organizational partnerships for inclusion in Phase II. Each FHT and CHC identified up to 20 inter-organizational partnerships they currently participate in, and were then asked to narrow this list to 3 of the most important partnerships from this list. The list of the 3 most important organizational partnerships resulted in the sampling pool for Phase II of the study. Based on the inclusion criteria below, only one organizational partnership was identified per FHT and CHC, for data collection during Phase II. Similarly, since each FHT and CHC identified up to 3 partnerships with MHA organizations, using the inclusion criteria below, we identified a list of eligible MHA organizations that had partnerships with FHTs and CHCs (as identified by the FHTs and CHCs). Using a similar approach (described below), we selected one organizational partnership per MHA organization for data collection during Phase II.
Due to response burden, it was not feasible to ask respondents from FHTs, CHCs or MHAs organizations to answer questions about every existing organizational partnership. It is likely that the respondents would not have the required time, nor would they be able to provide accurate information if they were requested to recall several partnerships at the same time. We narrowed the eligible organizational partnerships using the following inclusion criteria: the organizational partnership has existed for a minimum of 6 months; the organizational partnership is with a registered MHA organization or specialized program; the organization has demonstrated a focus on MHA; and informed consent was provided from the organization’s ED (or equivalent). Partnerships with individual clinicians (e.g., psychiatrists) who are not part of a larger organization were excluded.

Of the eligible organizational partnerships identified for each FHT, CHC and MHA organization (using the above criteria), we randomly selected partnerships, attempting to balance the number of ‘yes’ formalization category and ‘no’ formalization category, for FHTs, CHCs and MHAs organizations. We anticipated identifying approximately 22 FHTs, 11 with ‘yes’ formalization, and 11 with ‘no’ formalization; similarly for CHCs and MHAs organizations. For MHAs organizations, we included the partnerships they had with FHTs and CHCs. The process of identifying eligible organizational partnerships for Phase II started in Phase I of the study. As the data were collected, we analyzed the data on formalization so that we could immediately follow-up with participants, minimizing the time between data collection points.

**Participant Eligibility Criteria**

For each organizational partnership identified per FHT, CHC, and MHA organization, all individuals who were considered knowledgeable about the quality of the partnership processes were eligible to participate. Regarding administrative collaboration, a ‘knowledgeable person’ was defined by adopting the description provided by Weiss et al. (2002): “any partner who has interaction with other partners and is familiar with the work of the partnership as well as its
leadership, administration, resources, decision-making processes, and the challenges it faces” (p. 686). Eligible participants could include both administrators and service providers. Regarding service delivery collaboration, a ‘knowledgeable person’ was defined as any individual who provides services to patients and works across organizations. Eligible participants could include both service providers and administrators who have a dual role and provide direct patient care.

It is important to note that data were not collected from both of the partnering organizations; only one organization completed the online survey. For example, once a FHT-MHA partnership was identified, only FHT staff members who were involved in this specific partnership with the identified MHA organizational partner were invited to complete the Phase II survey. It was not an objective of the study to match or compare partnership data on responses to the Phase II survey.

The RA contacted one main contact (as identified by the ED or equivalent) for each FHT, CHC and MHA organization to facilitate the identification of all eligible participants for the responding organization and to gather contact information (phone and email). The RA explained the study to each participant and obtained informed verbal consent. Participants were asked to complete only the relevant sections of the survey (reminders of the eligibility criteria were provided in the survey). Each FHT, CHC and MHA organization that participated in Phase II was given a unique organizational code (for FHTs and CHCs, the same organizational code from Phase I was used). Each individual participant from each organization was then given a unique survey code that was linked to the primary organizational code. The participants name never appeared with the survey code, except in a master file that was kept in a locked file and separate from the data collected to preserve confidentiality.
Phase II: Surveys & Measurement Tools

Once the partnership of interest was determined for each participating FHT, CHC and MHA organization, an online survey was administered using “Survey Monkey”. All eligible participants from each FHT, CHC and MHA organization were sent an email with the following information: an information letter, confirmation that the organization’s participation was consented by the ED (or equivalent), a unique participation code, and a link to complete the Phase II online survey. Participants had the option to complete the survey over the phone, although no one did. The survey was piloted with a small group of representatives to ensure clarity of the instructions and questions. The survey had 40 questions and took approximately 10 minutes to complete with an average of 4 questions per minute. Email reminders were sent out at days 5 and 10 (unless otherwise agreed upon with participants), with a maximum of 4 reminders sent to participants. A copy of the survey is provided in the appendix (Appendix B: Phase II Survey).

The survey contained three sections: 1) basic demographic information about each respondent; 2) information about administrative collaboration; and 3) information about service delivery collaboration. Participants were asked to complete the sections of the survey that were relevant to them and to skip questions they felt they were not able to answer (e.g., for service delivery collaboration, participants were asked to complete this section only if they provided direct patient care).

Administrative Collaboration: Partnership Self-Assessment Tool (PSAT)

Administrative collaboration was assessed using the PSAT (Weiss et al., 2002) subscale ‘partnership synergy’. The PSAT measures the quality of the inter-organizational partnership process. It has demonstrated adequate reliability and validity scores and has been administered within similar populations (Weiss et al., 2002, p. 688; Butt et al., 2008; Browne et al., 2007). Psychometrics of the scales and descriptions of the items of the three sub-scales are reported in detail elsewhere (Browne et al., 2007; Weiss et al., 2002; Lasker et al., 2001). The subscale had 9...
items that were scored on a 1-5 Likert scale (extremely well, very well, somewhat well, not so well, and not well at all; scored as 5, 4, 3, 2, 1, respectively; 9 items total). Sample question: “By working together, how well are these partners able to identify new and creative ways to solve problems?” Each individual participant’s score was averaged to yield a composite score between 1 and 5. In instances where data were missing, the average score was calculated using the number of responses provided for each scale. All of the available data provided by participants were included in the analysis.

**Service Delivery Collaboration: Collaborative Practice Questionnaire (CPQ)**

Service delivery collaboration was assessed using the CPQ. The CPQ measures level of and satisfaction with collaboration. The CPQ was originally developed and tested by Baggs (1994), and later revised by Way et al. (2001). Only the sub-scale measuring level of service delivery collaboration was administered. One modification was made in the instructions to participants, as they were asked to respond to the questions with respect to their inter-organizational partners and activities. Since 2001, the CPQ has been modified and used in a variety of settings, and has undergone additional reliability and validity testing (Way et al., 2001). The sub-scale measuring collaboration had 9 items that were scored -3 to +3 (7 point Likert scale) (strongly disagree, disagree, somewhat disagree, neutral, somewhat agree, agree, and strongly agree). Sample questions: “My collaborating partners and I: 1) plan together to make decisions about the care for the patients; 2) demonstrate trust in one another’s decision-making ability in making shared decisions about patient care. Each individual participant’s score was averaged to yield a composite score between -3 and +3. In instances where data were missing, the average was calculated using the number of responses provided. All of the available data provided by participants were included in the analysis.
**MHA Organizational Data**

Since the MHA organizations included in Phase II of the study did not participate in Phase I, an additional short survey was created to gather important information about the MHA organizational characteristics. Only one individual from each MHA organization (identified by the ED or equivalent) completed the survey. The survey had 18 questions and took approximately 8-10 minutes to complete with an average of 3 questions per minute. Email reminders were sent out at day 21 (unless otherwise agreed upon with participants), with a maximum of 4 reminders sent to participants. The survey included two main sections: participant demographics (position title, years in current position, age, gender, education); and organizational characteristics (LHIN region, operating budget, general population size, year established, governance model, MHA population focus). We received less than 50% response rate and decided not to include the MHA organizational data in the current study; a copy of this survey is not included in an appendix.

**Phase II: Data Analysis Methods**

For the quantitative data, descriptive statistics were calculated to characterize the respondents and the study population (inter-organizational partnerships). Means, standard deviation, medians and minimum/maximum scores (range) are reported as appropriate. Main study comparisons were conducted using t-tests to compare the level of collaboration by formal and informal groups (within group comparisons). Sub-group comparisons were conducted for staff role (administrator versus service provider) using a t-test and for organizational type (FHTs, CHCs and MHAs organizations) using a one-way ANOVA to assess within group differences. All analysis were two tailed and p values <0.05 were considered significant.
Phase III: Describing Participant Experiences in Inter-organizational Partnerships

Phase III: Objective
The objective of Phase III of the study was to explore how aspects of administrative collaboration and service delivery collaboration are experienced by the staff members who work in formal and informal partnerships.

Phase III: Sample
Participants who completed Phase II of the study were eligible to participate in a 45-60 minute phone interview during Phase III. The RA identified and contacted potential participants with the help of the main contact for each of the participating organizations. Sampling of the interview participants was purposeful so that selected participants spanned the following characteristics: type of organization (FHT, CHC and MHA organization), formal and informal partnerships, role (administrator, service provider), and gender. Potential participants were contacted by phone and email, and were invited to participate in the phone interview. Upon request, information about the study was provided during a short phone call with the RA, and if he/she agreed to participate, each individual was provided with a consent form and the phone interview was scheduled with the lead researcher. All of the interviews were completed by the same lead researcher. At the start of the interview, verbal informed consent was obtained. In total, 11 administrators and 9 service providers were interviewed. The interviews were digitally recorded and transcribed. Interviewees were provided with a $20 gift certificate in appreciation for their participation.

Phase III: Interview Guides
The conceptual framework for the study informed the semi-structured interview guide and questions. The selection of types of interview questions was guided by the typology proposed by Patton (2002). Two separate interview schedules were developed; one for administrators and
another for service providers. Both guides contained general questions about the partnership (e.g., partnership description, rationale for the partnership) and open-ended questions about participants’ experience and partnerships in general. Each guide contained unique questions for administrators focusing on administrative collaboration or unique questions for service providers on service delivery collaboration. Copies of the two interview guides are provided in the appendix (Appendix C: Phase III Interview Guide – Administrators; and Appendix D: Phase III Interview Guide – Service providers).

**Phase III: Data Collection Methods & Analysis**

Each individual transcript was given a unique code. The code did not match the participant’s code from Phase II, nor were the two codes linked in any way. The participant’s full name never appeared with the transcript code, except in a master file that was kept in a protected file and separate from the data collected to preserve confidentiality.

During Phase III of the study, the interviewing and data analysis were conducted simultaneously. As the lead researcher conducted the interview, she reviewed the participant’s responses. Such on-the-spot analysis directed the interviewer’s probes and follow-up questions. In addition, the researcher reviewed completed interviews while Phase III data collection was still ongoing. The researcher was able to use her developing analysis to revise the interview questions, as needed. Data analysis was stopped when saturation of key themes was achieved. Computer-assisted analysis (e.g., NVivo) was used to help facilitate data storage, coding, retrieval, comparing and linking (Patton, 2002).

Three members of the research team (thesis advisor, lead researcher, and research assistant) were initially involved in developing the coding key used to code the interview transcripts. We independently coded a small sample of the interview transcripts, and then met to review and discuss our observations and codes. We reviewed each transcript line by line, noting the content we
had coded, the label provided, the rationale for selecting the code, and any additional observations about the content of the transcript. Differences in perspectives were discussed until we agreed on an approach; no significant issues were experienced. Reflexivity, a process whereby the researcher acknowledges his/her own biases, values, and interests, was transparent during data analysis. The lead researcher recorded her observations and reflections in an observation book, and used these reflections to identify questions for consideration, that were then discussed in collaboration with the main thesis advisor, or with the entire lead research team (if needed).

A single coding key was produced for the interview transcripts for administrators (see Appendix E) and another for the transcripts for service providers (see Appendix F). The lead researcher then proceeded to code all of the transcripts using the appropriate coding key, preparing the data for NVivo. Using NVivo, the data were organized according to the main codes, and the lead researcher proceeded to review the data for the main themes, identifying similarities and differences in the responses from participants in formal versus informal partnerships. Analysis and interpretation of the data set was completed solely by the lead researcher, who used both the conceptual framework and the interview guides as the foundation for organizing and presenting the qualitative findings.

**Analysis & Presentation of Research Findings**

Overall, the current research study used a mixed methods approach, with three distinct (but related) Phases of data collection. An initial analysis was completed independently for each Phase of the study. In organizing and integrating the data for presentation in scientific journals, a mixed methods approach was used and the data were organized into three main papers based on specific themes and the research questions that guided the study. The results of Phase I of the study are reported in Chapter 5 (Paper 1). The finding from Phase II (quantitative methods) and III (qualitative methods) of the study were divided into two separate papers. Chapter 6 (Paper 2)
presents a mixed method paper and focuses on the association between formalization and administrative collaboration. Chapter 7 (Paper 3) also presents a mixed method paper and focuses on the association between formalization and service delivery collaboration.

**Ethical Considerations**

Ethics approval for the research study was obtained through the University of Toronto’s Research Ethics Board. Prior to beginning data collection at each Phase, participants were informed about the nature and purpose of the research and the context of the overall research project. Participation in the study was voluntary, and participants could have discontinued their involvement at any time. Any information that was provided by participants, or observed by the researcher, was treated as confidential. Since the data collected in Phase I was used to select eligible participants for Phase II, the data collected was confidential, but not anonymous by organization. Similarly, the data collected in Phase II was used to frame the interviews in Phase III. When the Phase III data were analyzed, they were presented in a manner that ensured the anonymity of responses (during both Phase III and in the reporting of the study results). Only members of the research team had access to the data for analysis.
Chapter 5 (Paper 1): Inter-Organizational Partnerships in Primary Mental Health Care -- An Environmental Scan

This Chapter presents Paper #1 of the 3-paper thesis option.

Introduction

Adults with complex mental health and addiction needs experience frustration and challenges when seeking health care. While the majority of Canadians access the health care system through primary health care and their family physician, people with MHA needs require services from multiple service providers who are located in multiple service organizations (AOHC, 2008; Boydell et al., 2008; Durbin et al, 2001). An estimated 40% of individuals seen in primary care have a mental health problem and approximately 25% have a diagnosed psychiatric disorder (CMHA, 2006). People with MHA problems are more likely to have poorer physical health status, and greater morbidity and mortality from physical health problems than people without mental illnesses (CMHA, 2006). People within the MHA systems also have more difficulty accessing primary care than the general population. A challenge has been to ensure the continuity of care for patients as they access services (Durbin et al., 2004; Durbin et al., 2006), while increasing the quality, accessibility and timeliness of the services they need.

The process of integrating health systems and services is a key strategy for maintaining and improving the health and wellbeing of people living in Canada (Romanow, 2002). A growing body of evidence suggests that integrated systems and services of care will lead to better health outcomes (Gillies et al., 2006; Suter et al., 2007; Craven & Bland, 2006; Provan et al., 2007; Boydell et al., 2008; Kates et al., 2010), reduced duplication of services (D’Amour et al., 2003), and continuity of patient care (Durbin et al., 2004; Durbin et al., 2006). Despite efforts to increase system integration, there are still three separate systems spanning physical health, mental health, and addictions.
Health care reform has included regionalization, an emphasis on community partnerships, and a move towards the delivery of patient-centred, interprofessional team-based care. While there is a need to work better together at organizational and service delivery levels, there are still both service gaps and unnecessary duplications. Continuity of care is deficient and patients struggle to navigate a complex, disconnected series of human service systems. This means that people have trouble accessing services when and where they need them, and they are not able to access health (or other) service providers who have adequate skills to serve them. With millions of dollars being invested into primary care and mental health and addictions, the development of increasingly complex interconnections among organizations and service providers requires continued exploration. How might we facilitate stronger inter-organizational partnerships to better meet service needs? How might we help service providers work better together across organizations? To answer these questions, we must have a better understanding of the current context and existing partnership activities.

The purpose of the current study was to complete an environmental scan of the existing inter-organizational partnerships that FHTs and CHCs have with community MHA organizations in Ontario. Olsen et al. (2007) identify CHCs and FHTs as the main interdisciplinary, primary care delivery models in Ontario. FHTs and CHCs were selected as the population of interest because they are interdisciplinary primary health care organizations that have mandates to both create community partnerships and provide interprofessional, team-based services. The current study examined the inter-organizational partnerships that provide services to adults with complex mental health and addiction needs.

The Ontario Context

A Move to Regional Planning: Ontario LHINs & their IHSPs

In 2006, the Ontario MOHLTC created LHINs, shifting the planning, funding and integration of health service responsibilities from a provincial to a regional level. LHINs are considered the local
decision-makers with respect to services within each community, for a defined set of health service provider organizations; they do not provide direct services. Collectively, the LHINs oversee approximately $20.3 billion health care dollars. CHCs and MHAs organizations are included in the LHIN list of health service organizations (among others); FHTs are not and receive their direction and funding from the MOHLTC.

Since 2006-07, LHINs have been working with organizations in their communities to develop new programs, strengthen existing programs, and foster community partnerships to improve mental health and reduce addictions. The first major initiative of the LHINs was to develop Integrated Health Service Plans (IHSPs), a three-year strategic plan that is aligned with provincial strategic directions provided by the MOHLTC. IHSPs are unique to each LHIN, and provide a foundation for LHIN planning initiatives and include integration priorities and action plans for creating an accessible, coordinated and integrated local health system. An initial review of the first IHSPs released in 2007 suggested that one LHIN identified mental health or addictions as a special population, and 12 identified population-specific strategies related to mental health or addictions (Bhasin & Williams, 2007). A more focused review of the IHSPs was later completed to assess the degree to which the IHSPs addressed MHA issues (Addictions Ontario et al., 2007). The key findings indicate that every LHIN addressed MHAs to some extent and that MHAs are a priority for 7 LHINs and a sub-priority for 5 LHINs. However, the authors reported that access, integration and service gaps were not consistently addressed and overall, the LHINs do not adequately understand the context for MHA services and needs of MHA patients (Addictions Ontario et al., 2007).

Community Health Centres: A History of Partnerships & Interprofessional Practice

Ontario CHCs (including: CHC satellites and Aboriginal Health Access Centres, AHACs) are non-profit, community-governed organizations that are sponsored and managed by community
boards. CHCs were established over 40 years ago, and have a history of providing interprofessional services and working with community partners.

Two recent reports provide insights into the partnership-related activities and characteristics of CHCs (AOHC, 2008; AOHC, 2010). Several key themes were noted. First, many patients of CHCs have complex needs, as demonstrated by the number of providers a patient may see in a single visit (e.g., in 2006-07, over 8,000 clients saw more than 4 providers in a single visit; the percentage of total patients was not provided) (AOHC, 2008). Second, in examining the patient populations distributed by LHIN region, 9 of 13 (one LHIN did not have CHCs) identified the MHA population as a priority (AOHC, 2008). Third, almost all CHC activities (i.e., programs, services and community initiatives) involve partnerships with other community and/or health-service providers (AOHC, 2008). CHCs define partners as “organizations that CHCs work closely with to jointly operate programs and services or work on joint planning or advocacy initiatives to benefit their communities” (AOHC, 2008, p.29). CHCs reported over 1,275 partnerships in total (AOHC, 2008), with an average range of 17-24 partners per CHC (AOHC, 2008; AOHC, 2010). Approximately 96% of CHC integrations were coordination or partnership activities; the types of stakeholders they partner with are almost evenly split between LHIN and non-LHIN funded organizations/services (AOHC, 2010). The most common partnerships were among CHCs (30%), followed by community and social services (12%) and primary care specialists (12%; of which FHTs were one of the groups listed); partnerships with MHAs organizations were reported by 6.23% of CHCs (approx 6 of 56 CHCs) (AOHC, 2010).

**Family Health Teams: The Newest Primary Care Teams**

In 2005, the MOHLTC announced new interprofessional team-based, primary care organizations called Family Health Teams. FHTs receive their funding from and report directly to the MOHLTC, and are not included as part of the LHIN funded health service organizations. FHTs
operate using one of three governance models: community-based; provider-based; or mix of community- and provider-based (MOHLTC, 2006).

The literature on FHTs activities is limited (Rosser et al., 2011), with some studies exploring interprofessional collaboration broadly (Goldman et al., 2010a; Goldman et al., 2010b; Howard et al., 2011; Rosser et al., 2011), and only a few studies exploring the integration of MHA services into primary care settings and community partnerships (Mulvale & Bourgeault, 2007; Mulvale et al., 2008; Sherman et al., 2010). The development (Mulvale & Bourgeault, 2007) and testing of a conceptual framework provided insights into the contextual factors that facilitate and inhibit collaboration (Mulvale et al., 2008). In examining the local health system factors, the authors reported that many FHTs had developed linkages with MHA organizations, emphasizing the need for community-wide service planning (Mulvale et al., 2008). However, descriptive characteristics about the nature of these types of partnerships were not included in the study. A study of northern Ontario FHTs suggested that success rates in efforts to integrate mental health and psychiatric services into FHTs vary by organization and that pre-existing organizational relationships are an important consideration when assessing perceptions of partnerships and collaborations (Sherman et al., 2010).

The objectives of the study were to: 1) describe the general organizational characteristics of FHTs and CHCs, as well as their characteristics related to the provision of MHA services (i.e., population focus on MHA); and 2) to describe the current inter-organizational partnerships that FHTs and CHCs have with community MHA organizations (i.e., number of partnerships; duration of partnerships; frequency of partnership activities; formal inter-organizational agreements; administrative service ties; and service delivery ties).
Methods

This paper is the result of a comprehensive mixed methods research study on inter-organizational partnerships in the province of Ontario (Canada). The study was comprised of three distinct phases, and data were collected between September 2009 and March 2010. Phase I (the current paper) provided an environmental scan of the existing inter-organizational partnerships among FHTs and CHCs and their community MHA organizational partners. Phase II examined the association between the formalization of inter-organizational partnerships and two forms of collaboration (administrative and service delivery collaboration). Phase III explored the experiences of administrators and service providers who work across organizations. The results of Phase II and III of the study are reported elsewhere. Approval for the study was obtained through the University of Toronto’s Research Ethics Board.

Sampling Strategy

As of September 2009, all existing FHTs (n=139) and CHCs (n=71) organizations in Ontario were invited to participate in the study (N=210). For the purposes of this study, CHCs, AHACs and CHC satellites were grouped into one organizational category. Organizational contact information was obtained using the internet. Consent for the organization’s participation was obtained from the ED (or equivalent) during Phase I by a trained research associate (RA). Only one individual from each organization completed the survey, and was identified by the ED (or equivalent). For Phase I, the individual considered to be a ‘knowledgeable person’ was defined as “the individual most knowledgeable about the organization’s inter-organizational partnership policies and procedures”, specifically in relation to formal or informal inter-organizational partnerships with community MHA organizations, and specifically for the provision of services to adults with complex mental health and addiction needs. Of the eligible 210 organizations, 151 surveys were completed and considered valid, yielding the following response rates: 69.8% for FHTs (n=97); 76.0% for CHCs (n=54); and an overall response rate of 71.9%. The most common reason for declining participation in the study
was due to a lack of perceived time or availability (e.g., many organizations were involved in multiple research studies).

**Measurement**

The electronic self-report survey was piloted with a small representative sample of participants. An inter-organizational partnership was defined as two organizations (dyad) that work towards a common goal and provide services to a common client population. A formal partnership was considered when the two organizations shared a written agreement. The survey included three main sections: *participant demographics* (position title, years in current position, age, gender, education); *organizational characteristics* (LHIN region, operating budget, year established, governance model, population focus on MHA); and *inter-organizational partnerships* (number, length and activity level of partnerships; formalization; administrative ties; and service delivery ties). The survey contained 34 questions (open and closed-ended) and took approximately 20-30 minutes to complete. Participants were emailed a link to complete the survey online.

**Analysis & Results**

Data were collected using Survey Monkey and the raw data were exported into an excel database. The data were cleaned, removing invalid responses (e.g., duplicate entries), and the final data set was imported to SAS to complete the analysis. Descriptive statistics (means, standard deviations, medians, and ranges) are reported for the participants, organizational characteristics and the inter-organizational partnerships. Sub-group comparisons by organizational type (FHTs versus CHCs) are reported where appropriate. Results are provided for valid responses (noting missing responses where applicable).

**Respondent Characteristics**

The total sample size for this survey was 151 organizations (97 FHTs and 54 CHCs). Of those respondents, 79% were female (n=119), and 21% were male (n=31). The average age reported was
48 (SD = 4.17, range 26-68 years). Sixty-four percent of respondents (n=97) had a university graduate degree, 19% (n=28) had an undergraduate degree, 15% (n=22) a diploma, and 3% (n=4) reported that their highest level of education was high school. When asked about their current position, 36.7% (n=56) of respondents were service providers, followed by 33.3% CEO/Directors, 12.4% managers, 11.1% co-ordinators/leads, and 6.5% administrators. The most common types of service providers included: social worker, mental health worker, and nurse (respectively). In reporting how long respondents have occupied their current position, the mean response was 4 years (SD = 4.15; range 0.8-24.6 years).

Organizational Characteristics

Organization Demographics

In terms of organizational characteristics, 64% (n=97) of respondents identified their organization as a FHT (including Academic FHTs, community FHTs, and hospital-based FHTs), and 36% (n=54) identified their organization as a CHC (including CHC Satellites, and AHACs). Distribution of these organizations across the LHINs is shown in Table 12.

Table 12: Frequency of Organization by LHIN Region

<table>
<thead>
<tr>
<th>LHIN</th>
<th>FHTs N=97 n(N), %</th>
<th>CHCs, N=54 n(N), %</th>
<th>Total, N=151 n(N), %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>4(6), 66.7</td>
<td>2(2), 100</td>
<td>6(8), 75.0</td>
</tr>
<tr>
<td>Central East</td>
<td>5(6), 83.3</td>
<td>5(7), 71.4</td>
<td>10(13), 76.9</td>
</tr>
<tr>
<td>Central west</td>
<td>3(4), 75.0</td>
<td>1(2), 50.0</td>
<td>4(6), 66.7</td>
</tr>
<tr>
<td>Champlain</td>
<td>6(13), 46.2</td>
<td>6(16), 37.5</td>
<td>12(29), 34.5</td>
</tr>
<tr>
<td>Erie St.Clair</td>
<td>5(7), 71.4</td>
<td>8(11), 72.7</td>
<td>13(18), 72.2</td>
</tr>
<tr>
<td>Hamilton Niagara Haldimand Brant</td>
<td>6(13), 46.2</td>
<td>3(11), 27.3</td>
<td>9(24), 37.5</td>
</tr>
<tr>
<td>Mississauga Halton</td>
<td>5(6), 83.3</td>
<td>0(0), -</td>
<td>5(6), 83.3</td>
</tr>
<tr>
<td>North East</td>
<td>15(17), 88.2</td>
<td>4(17), 23.5</td>
<td>19(34), 55.9</td>
</tr>
<tr>
<td>North Simcoe Muskoka</td>
<td>4(6), 66.7</td>
<td>1(1), 100</td>
<td>5(7), 71.4</td>
</tr>
<tr>
<td>North West</td>
<td>10(12), 83.3</td>
<td>3(5), 60.0</td>
<td>13(17), 76.5</td>
</tr>
<tr>
<td>South East</td>
<td>8(15), 53.3</td>
<td>5(6), 83.3</td>
<td>13(21), 61.9</td>
</tr>
<tr>
<td>South West</td>
<td>13(16), 81.3</td>
<td>3(4), 75.0</td>
<td>16(20), 80.0</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>7(9), 77.8</td>
<td>8(24), 33.3</td>
<td>15(35), 42.9</td>
</tr>
<tr>
<td>Waterloo Wellington</td>
<td>6(9), 66.7</td>
<td>5(8), 62.5</td>
<td>11(17), 64.7</td>
</tr>
</tbody>
</table>
The most common governance model for the organizations was community-based (48.3%, n=73) (see Table 13). The definitions for the various governance models were adapted from MOHLTC (2006). *Community-based*: a registered non-profit organization governed by a board of directors including community representatives. *Provider-based*: an organization built of partnerships, professional corporations (for professions governed by the Regulated Health Professionals Act) or individual providers working together through a contract of association. They are governed by an executive team or established as a non-profit corporation, governed by a board of directors. *Mixed* (community and provider): comprised of groups or individuals who come together through a contract of association. They have either an executive team or a non-profit corporation that is governed by a board of directors.

<table>
<thead>
<tr>
<th>Governance Model</th>
<th>FHTs, N=97 n(%)</th>
<th>CHCs, N=54 n(%)</th>
<th>Total, N=151 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based</td>
<td>23(23.7)</td>
<td>50(92.6)</td>
<td>73(48.3)</td>
</tr>
<tr>
<td>Provider-based</td>
<td>38(39.2)</td>
<td>0(0)</td>
<td>38(25.2)</td>
</tr>
<tr>
<td>Mixed</td>
<td>25(25.8)</td>
<td>4(7.4)</td>
<td>29(19.2)</td>
</tr>
</tbody>
</table>

Note: Missing: FHTs (n=11); CHCs (n=0); Total (n=11)

When asked about the date of the establishment of the organization, responses ranged between the years 1883 and 2009, with the average organization being established in 1996 (SD=16). The majority (n=89, 58.9%) of organizations have an operating budget of over $1,000,000 (see Table 14). Most FHTs and CHCs have a population focus on adult mental health (n=90, 68.2%). Most organizations do not have a focus on adult addictions (n=76, 69.7%) (see Table 15).
Table 14: Organizational Annual Operating Budget

<table>
<thead>
<tr>
<th>Annual Operating Budget</th>
<th>FHTs, N=97 n(%)</th>
<th>CHCs, N=54 n(%)</th>
<th>Total, N=151 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than $500,000</td>
<td>8(8.2)</td>
<td>0(0)</td>
<td>8 (5.3)</td>
</tr>
<tr>
<td>$500,000 to 1,000,000</td>
<td>26(26.8)</td>
<td>0(0)</td>
<td>26 (17.2)</td>
</tr>
<tr>
<td>over $1,000,000</td>
<td>40(41.2)</td>
<td>49(90.1)</td>
<td>89 (58.9)</td>
</tr>
</tbody>
</table>

Note: Missing: FHTs (n=23); CHCs (n=5); Total (n=28)

Table 15: MHA Population Focus of FHTs and CHCs Combined

<table>
<thead>
<tr>
<th>MHA Population Focus</th>
<th>Yes, N=123 n(%)</th>
<th>No, N=109 n(%)</th>
<th>Total Missing, N=151 N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organization have a population focus on</td>
<td>90(68.2)</td>
<td>42(31.8)</td>
<td>19(12.6)</td>
</tr>
<tr>
<td>Adult Mental Health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your organization have a population focus on</td>
<td>33(30.3)</td>
<td>76(69.7)</td>
<td>42(27.8)</td>
</tr>
<tr>
<td>Adult Addiction?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Inter-Organizational Partnerships

The majority of FHTs and CHCs (n=108, 71.5%) reported that they have an inter-organizational partnership with at least one other health provider organization to provide services to adults with complex mental health and addiction needs (FHTs, n=69; CHCs, n=39), while 28.5% (n=43) reported they did not (FHTs, n=28; CHCs, n=15). Of the organizations who have partnerships, most have between 1-3 partnerships (n=59, 54.7%), while some organizations reported as many as 20 partnerships. The total number of organizational partnerships reported by the respondents was 513 (see Table 16).
Table 16: The Number of Partnerships Per Organization

<table>
<thead>
<tr>
<th>Partnerships per Organization</th>
<th>FHTs, N=69 n(%)</th>
<th>CHCs, N=39 n(%)</th>
<th>Total, N=108 n(%)</th>
<th>Total # of Partnerships, N=513 n(FHTs; CHCs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18(26.1)</td>
<td>8(20.5)</td>
<td>26 (24.1)</td>
<td>26 (18, 8)</td>
</tr>
<tr>
<td>2</td>
<td>11(15.9)</td>
<td>8(20.5)</td>
<td>19 (17.6)</td>
<td>38 (22, 16)</td>
</tr>
<tr>
<td>3</td>
<td>8(11.6)</td>
<td>6(15.4)</td>
<td>14 (13.0)</td>
<td>42 (24, 18)</td>
</tr>
<tr>
<td>4</td>
<td>3(4.3)</td>
<td>3(7.6)</td>
<td>6 (5.6)</td>
<td>24 (12, 12)</td>
</tr>
<tr>
<td>5</td>
<td>7(10.1)</td>
<td>3(7.6)</td>
<td>10 (9.3)</td>
<td>50 (35, 15)</td>
</tr>
<tr>
<td>6</td>
<td>3(4.3)</td>
<td>2(5.2)</td>
<td>5 (4.6)</td>
<td>30 (18, 12)</td>
</tr>
<tr>
<td>7</td>
<td>5(7.2)</td>
<td>0(0)</td>
<td>5 (4.6)</td>
<td>35 (35, 0)</td>
</tr>
<tr>
<td>8</td>
<td>1(1.6)</td>
<td>2(5.2)</td>
<td>3 (2.8)</td>
<td>24 (8, 16)</td>
</tr>
<tr>
<td>9</td>
<td>3(4.3)</td>
<td>1(2.6)</td>
<td>4 (3.7)</td>
<td>36 (27, 9)</td>
</tr>
<tr>
<td>10</td>
<td>5(7.2)</td>
<td>1(2.6)</td>
<td>6 (5.6)</td>
<td>60 (50, 10)</td>
</tr>
<tr>
<td>11</td>
<td>4(5.8)</td>
<td>1(2.6)</td>
<td>5 (4.6)</td>
<td>55 (44, 11)</td>
</tr>
<tr>
<td>13</td>
<td>0(0)</td>
<td>1(2.6)</td>
<td>1 (0.8)</td>
<td>13 (0, 13)</td>
</tr>
<tr>
<td>20</td>
<td>1(1.6)</td>
<td>3(7.6)</td>
<td>4 (3.7)</td>
<td>80 (20, 60)</td>
</tr>
</tbody>
</table>

Note: 108 of the participants reported their actual number of current organizational partnerships. Each respondent could identify up to 20 inter-organizational partnerships. Thus, a maximum of 2,160 (108x20) partnerships could have been identified. In total, 513 partnerships were identified across the 108 organizations.

Participants were asked to indicate how long each partnership has existed (year formed).

Data were then grouped into the following five categories by year formed: 2009; 2008-2004; 2003-1999; 1998-1994; 1993 and earlier. For the 482 partnerships that were reported, the majority of the partnerships were created between 2004-2008 (n=300, 62.2%), suggesting that most partnerships are approximately 1-5 years old (see Table 17).

Table 17: Year the Partnership Was Formed

<table>
<thead>
<tr>
<th>Year Partnership Formed</th>
<th>Length of Partnership in Years</th>
<th>FHTs, N=287 n(%)</th>
<th>CHCs, N=195 n(%)</th>
<th>Total, N=482 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>&lt;1</td>
<td>22(7.7)</td>
<td>11(5.6)</td>
<td>33(6.8)</td>
</tr>
<tr>
<td>2008-2004</td>
<td>1-5</td>
<td>234(81.5)</td>
<td>66(33.8)</td>
<td>300(62.2)</td>
</tr>
<tr>
<td>2003-1999</td>
<td>6-10</td>
<td>3(1.0)</td>
<td>60(30.8)</td>
<td>63(13.1)</td>
</tr>
<tr>
<td>1998-1994</td>
<td>11-15</td>
<td>4(1.4)</td>
<td>24(12.3)</td>
<td>28(5.8)</td>
</tr>
<tr>
<td>1993 and earlier</td>
<td>&gt;15</td>
<td>24(8.4)</td>
<td>34(17.5)</td>
<td>58(12.1)</td>
</tr>
</tbody>
</table>

Note: Missing: FHTs, N=313 (n=26, 8.3%); CHCs, N=200 (n=5, 2.5%); Total, N=513 (n=31, 6.0%)
Participants were asked to indicate how often members of the partnership interact (activity level) according to the following six categories: daily; several times per week; once per week; 2-3 times per month; once per month; not sure. Data were reported for 503 partnerships, and indicated that most partnerships are active on a monthly basis (includes 2-3 times per month and once per month categories; n=231, 45.9%) (versus daily or weekly) (see Table 18).

**Table 18: Partnership Activity Level**

<table>
<thead>
<tr>
<th></th>
<th>FHTs, N=303 n(%)</th>
<th>CHCs, N=200 n(%)</th>
<th>Total, N=503 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>daily</td>
<td>7 (2.3)</td>
<td>21 (10.5)</td>
<td>28 (5.6)</td>
</tr>
<tr>
<td>several times per week</td>
<td>37 (12.2)</td>
<td>24 (12.0)</td>
<td>61 (12.1)</td>
</tr>
<tr>
<td>once per week</td>
<td>25 (8.3)</td>
<td>26 (13.0)</td>
<td>51 (10.1)</td>
</tr>
<tr>
<td>2-3 times per month</td>
<td>63 (20.8)</td>
<td>39 (19.5)</td>
<td>102 (20.3)</td>
</tr>
<tr>
<td>once per month</td>
<td>94 (31.0)</td>
<td>35 (17.5)</td>
<td>129 (25.6)</td>
</tr>
<tr>
<td>not sure</td>
<td>77 (25.4)</td>
<td>55 (27.5)</td>
<td>132 (26.3)</td>
</tr>
</tbody>
</table>

Note: Missing: FHTs, N=313 (n=10, 3.2%); CHCs, N=200 (n=0, 0%); Total, N=513 (n=10, 1.9%)

When asked to indicate if the partnership shared a formal written agreement of any kind, 80.8% (n=395) of the reported partnerships did not have an agreement (and were classified as informal partnerships); while 19.2% (n=94) reported they had a formal agreement (see Table 19).

**Table 19: Frequency of Formal Partnerships**

<table>
<thead>
<tr>
<th>Does the partnership share a formal written agreement of any kind?</th>
<th>FHTs, N=291 n(%)</th>
<th>CHCs, N=198 n(%)</th>
<th>Total, N=489 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (Formal partnership)</td>
<td>28 (9.6)</td>
<td>66 (33.3)</td>
<td>94 (19.2)</td>
</tr>
<tr>
<td>No (Informal partnership)</td>
<td>263 (90.4)</td>
<td>132 (66.7)</td>
<td>395 (80.8)</td>
</tr>
</tbody>
</table>

Note: Missing: FHTs, N=313 (n=22, 7.0%); CHCs, N=200 (n=2, 0%); Total, N=513 (n=24, 1.9%)

In the final section of the survey, respondents were asked to select up to three inter-organizational partnerships to provide more detailed information about their formal agreements. If the organization had more than three partnerships, the respondent was asked to select the three most significant partnerships (a definition of ‘significant partnership’ was not provided to participants).
For each formal partnership identified, participants were asked to specify the type of agreement used. Service agreements were reported most frequently, followed by policies and procedures, memorandum of understanding, referral agreement, satellite agreement, and release of patient information agreement (respectively). For each formal partnership agreement identified, participants were asked to provide additional information about the administrative and service ties outlined, described or included in the agreement (see Table 20). The most frequently reported administrative service ties were shared human resources and shared resources (e.g., space, equipment, education). The most frequently reported service delivery ties were joint services (e.g. service referrals, received/sent) and shared patient information.

Table 20: Frequencies for Administrative & Service Delivery Ties in Formal Agreements

<table>
<thead>
<tr>
<th>Type of Service Ties</th>
<th>FHTs, N=28 n(%)</th>
<th>CHCs, N=66 n(%)</th>
<th>Total, N=94 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Service Ties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared resources</td>
<td>17(60.7)</td>
<td>42(63.6)</td>
<td>59(62.8)</td>
</tr>
<tr>
<td>Shared human resources</td>
<td>12(42.9)</td>
<td>31(47.0)</td>
<td>43(45.7)</td>
</tr>
<tr>
<td>Inter-agency meetings</td>
<td>11(39.3)</td>
<td>27(40.9)</td>
<td>38(40.4)</td>
</tr>
<tr>
<td>Shared administrative information</td>
<td>13(46.4)</td>
<td>24(36.4)</td>
<td>37(39.4)</td>
</tr>
<tr>
<td>Administrative coordination/governance structure</td>
<td>10(35.7)</td>
<td>16(24.2)</td>
<td>26(27.7)</td>
</tr>
<tr>
<td>Shared financial resources</td>
<td>5(17.9)</td>
<td>13(19.7)</td>
<td>18(19.1)</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>17(60.7)</td>
<td>21(31.8)</td>
<td>38(40.4)</td>
</tr>
<tr>
<td>Service Delivery Ties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint services (e.g. service referrals, received/sent)</td>
<td>27(96.4)</td>
<td>39(59.0)</td>
<td>66(70.2)</td>
</tr>
<tr>
<td>Shared patient/client information</td>
<td>24(85.7)</td>
<td>33(50.0)</td>
<td>57(60.6)</td>
</tr>
<tr>
<td>Joint consultations</td>
<td>19(67.9)</td>
<td>28(42.4)</td>
<td>47(50.0)</td>
</tr>
<tr>
<td>Case coordination</td>
<td>17(60.7)</td>
<td>25(37.9)</td>
<td>42(44.7)</td>
</tr>
<tr>
<td>Co-location of providers</td>
<td>14(50.0)</td>
<td>25(37.9)</td>
<td>39(41.5)</td>
</tr>
<tr>
<td>Joint programs in mental health and/or addictions</td>
<td>7(25.0)</td>
<td>27(40.9)</td>
<td>34(36.2)</td>
</tr>
<tr>
<td>Common intake and/or assessment forms</td>
<td>11(39.3)</td>
<td>16(24.2)</td>
<td>27(28.7)</td>
</tr>
<tr>
<td>Common management system</td>
<td>7(25.0)</td>
<td>8(12.1)</td>
<td>15(16.0)</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>9(32.1)</td>
<td>16(24.2)</td>
<td>25(26.6)</td>
</tr>
</tbody>
</table>
Discussion

This Ontario-based environmental scan sought to describe the MHA human resources of FHTs and CHCs, and provide an overview of the current inter-organizational partnerships among FHTs, CHCs and their community MHA organization partners, who work together to provide services to adults with complex MHA needs.

More than 71% of FHTs and CHCs have at least one partnership with a MHA organization (servicing adults with complex MHA needs), and most have between 1-3 partnerships (54.7%). A total of 200 partnerships were identified by 39 CHCs suggesting that the number of partnerships with MHA organizations has increased since 2008 (previously estimated total of 50-75 across all CHCs; AOHC, 2008). Results demonstrated an increase in the number of partnerships created during the first 4 years of FHT operations (234 created in 2004-08, an average of 58 partnerships per year, with 22 being formed in the year the study was conducted). Overall, we see an increase in the number of CHC partnerships from 2003 onwards. The importance of pre-existing organizational relationships (Sherman et al., 2010) was demonstrated in the results by the number of FHTs that reported partnerships older than the number of years the FHT had been in operation (i.e., 31 of the FHT partnerships were formed prior to 2004).

Most of the reported partnerships were informal (80.8%), supporting the results of previous research (AOHC, 2008; Polivka et al., 2001). Of the partnerships that were formal, 19.2% used service agreements as the most common shared inter-organizational agreement, consistent with previous work (AOHC, 2010). When compared, CHCs demonstrated a greater percentage of formal partnerships (33.3%) compared to FHTs (9.6%). Previous research has suggested that older organizations were more likely to create formalized partnerships, and organizations with smaller budgets (e.g., less than $100k) were less likely to formalize (Foster & Meinhard, 2002). Future research could continue to explore why FHTs and CHCs tend to have more informal partnerships.

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Overall, the activity level of staff involved in the partnerships was low, with 45.9% of staff interacting on a monthly basis, only 22.2% interacting weekly, and less than 6% interacting on a daily basis. What was surprising was that 26.3% were unsure of the level of interaction. These results were also consistent with previous research findings. For example, Smith and Mogro-Wilson (2007 & 2008) looked at collaboration with other agency staff in the last month: 58% had contacted their partners or involved them in treatment planning in the last month, and only 16% reported collaborating often or very often in the last month. Future research could explore factors that affect level of staff interaction.

Limitations

Several limitations of the current study provide opportunity for future research. First, it is important to consider the growing number of inter-organizational partnerships that FHTs and CHCs are engaged in, and the impact this has on respondents. Recall bias and social desirability bias are two potential limitations. It may be difficult for respondents to differentiate among the various partnerships (e.g., length of an informal partnership, activity level of staff members, number and type of staff involved in each partnership), which may influence the accuracy of their responses, or could increase response fatigue. In addition, the increased emphasis on community partnerships may result in respondents over-reporting the number of partnerships, particularly informal ones, which do not have formal written agreements. Over-reporting could dilute the results, as the respondents become increasingly unable to provide sufficient or accurate information about less prominent partnerships. Second, the study examined CHC and FHT partnerships with MHA organizations solely from the perspectives of the CHCs and FHTs. It was decided that collecting this information from the perspective of the MHA organizations (i.e., asking them to identify their partnerships with CHCs and FHTs) would require unnecessary duplication of resources and time. However, we did attempt to collect basic descriptive information about the MHA organizational
characteristics, but data collection was discontinued due to very low response rates. This information would have provided a more robust environmental scan and suggests an area for future research.

**Conclusion**

This study represents a first attempt to provide a description of the inter-organizational partnerships among primary care (CHCs and FHTs) and MHA organizations in Ontario. Since the number of community partnerships is increasing, it is critical for researchers and decision makers to consider strategies to standardize the collection of descriptive data, in order to track key partnership characteristics and behaviours at administrative and service delivery levels. Informal partnerships are predominant, and the details of these partnerships are not articulated in written agreements shared among partners. Capturing an accurate and more in-depth description of partnerships may become increasingly difficult if the number and complexity of community partnerships continue to increase, particularly if partnerships are informal. An initial step may be to better understand how informal partnerships are conceptualized by participants, including the structures and processes that define the partnerships in non-formalized ways.
Chapter 6 (Paper 2): Association Between Formalization & Administrative Collaboration

This Chapter presents Paper #2 of the 3-paper thesis option.

Introduction

Adults with complex mental health and/or addictions needs require services from a range of human service providers and organizations (AOHC, 2008; Boydell et al., 2008; Durbin et al, 2001). The integration and alignment of inter-organizational partnerships is critical for the delivery of quality, accessible and timely patient care (Durbin et al., 2004; Durbin et al., 2006). The responsibility and accountability for service implementation is increasingly placed among those who are closest to the patients and their needs (Lasker et al., 2001), particularly mental health and addiction services at the community level (Hartford et al., 2003; Wiktorowicz, 2005). Enhancing community partnerships and collaboration at the staff level have become strategies to address these issues.

More specifically, the importance of organizational partnership governance models has become of interest to those who lead partnerships (Wiktorowicz et al., 2010; Fleury, 2005; Lasker et al., 2001). Researchers have suggested that organizational structures such as the formalization of partnerships influence partnership functioning (Nylen, 2007; Isett & Provan, 2005; Foster & Meinhard, 2002; Lasker et al., 2001), the partnership process, and administrative collaboration among staff members who work across the partnership (Wiktorowicz et al., 2010; Florin et al., 200; Fleury, 2005; Kegler et al., 1998; Rogers et al., 1993). While the relationships between people are crucial and foundational (underscoring the importance of partnerships and collaboration) (Lasker et al., 2001), the association between formalized organizational partnership structures and collaboration as a staff practice is relatively unexplored.
There is preliminary support for the positive effects of formalization on the partnership process overall (Kegler et al., 1998; Rogers et al., 1993; Florin et al., 2000; D’Amour et al., 2004; Sicotte et al., 2002; Fleury, 2005; Fleury et al., 2004; Wiktorowicz et al., 2010). Combined, the results of these studies suggest that formalization of partnership structures may help: clarify the coordination and communication mechanisms across organizations; outline the resources required to support the partnership; determine decision-making processes, accountability mechanisms, or liabilities; and clarify the roles and responsibilities for each of the organizational partners and the staff. However, very few empirical studies have specifically examined the association between formalization and administrative collaboration.

The objectives of the study were to: 1) measure the association between formalization and administrative collaboration; and 2) explore how aspects of administrative collaboration are experienced by the administrators who work across organizations in both formal and informal partnerships.

**Conceptual Foundation**

The conceptual foundation for this study resulted from a review of the theoretical and empirical literature, spanning inter-organizational development (Schermerhorn, 1979; Parmigiani & Rivera-Santos, 2011; Sofaer & Myrtle, 1991; Barringer & Harrison, 2000), service integration (Dickinson, 2006; Lasker et al., 2001; Weiss et al., 2002; Butt et al., 2008; Browne et al., 2007), and collaborative practice (D’Amour et al., 2005; San Martin-Rodriguez et al., 2005; Craven & Bland, 2006; Oandasan et al., 2006; Kates et al., 2011; Reeves et al., 2010; HPRAC, 2008; HCC, 2009).

The literature describing the tensions that are experienced when organizations create, formalize and/or implement partnerships is divided into two perspectives – organizational economics and organizational theory (Parmigiani & Rivera-Santos, 2011; Barringer & Harrison, 2000; Hill and Lynne, 2003; Vlaar et al., 2007b). In organizational economics (or rational choice
the theoretical paradigms used to explain the formation of partnerships primarily focus on exchanges or interactions between organizations. Theories sharing this perspective argue that partnerships form when it is more efficient for an organization to conduct activity through a close partner relationship than on its own, or through the market (e.g., transaction cost economics, resource-based view, agency theory). In organizational theory (social choice theories), the theoretical paradigms used to explain the formation of partnerships primarily focus on relationships and shared values (other than exchanges or interactions). Theories sharing this perspective argue that the formation of partnerships is often based upon prior relationships, trust, and histories between the partners (e.g., resource dependence, stakeholder theory, institutional theory, social networks). Organizations form partnerships to gain legitimacy, status or reputation based on their connections, or to reduce dependency and uncertainty. Formalization of partnerships could be used as a strategy to manage the rational and relational tensions for creating the partnership. Formalization may also be used as a strategy to better manage multiple inter-organizational relationships and/or improve organizational performance.

Researchers embracing a more holistic approach to understanding and examining inter-organizational relationships have recommended a blending of both rational and relational perspectives (Barringer & Harrison, 2000; Hill & Lynn, 2003; Parmigiani & Rivera-Santos, 2011), and avoiding deterministic or prescriptive approaches to their research. Partnerships are complex and a variety of perspectives are required to untangle the factors that contribute to organizational performance. Thus, the conceptual foundation for the current study embraces both rational and relational perspectives and does not apply one specific theoretical paradigm.

Methods

This paper is the result of a study on inter-organizational partnerships in the province of Ontario (Canada). The study was comprised of three distinct phases of data collection, with an
overall mixed methods study design. Phase I included an environmental scan of the existing inter-organizational partnerships among FHTs, CHCs and community MHA organizations that provide services to adults with complex mental health and/or addiction needs. Phases II and III of the study were conducted concurrently. Phase II examined the association between formalization and collaboration as a staff practice. Phase III explored how the administrators and service providers who work across organizations experienced two different forms of collaboration. The current paper provides a summary of the data collected from Phases II and III specifically focusing on the data related to administrative collaboration. The data from Phase I, and Phases II and III (related to service delivery collaboration) is reported elsewhere. Detailed methods for Phase II and III, including sample size calculation, sampling strategy, and measures are reported elsewhere. Approval for the three phases of research was obtained through the University of Toronto’s Research Ethics Board.

In this paper, the quantitative and qualitative strands are presented separately, each with their own questions, data, analysis and inferences. In the discussion section, the findings are brought together to provide a more in-depth understanding of the association between formalization and administrative collaboration, and how these relationships are experienced by the administrators who participate in these partnerships.

**Main Study Variables**

Vlaar et al. (2007b) define formalizations as “the process of codifying and enforcing output and/or behaviour, and its outcomes in the form of contracts, rules and procedures” (p. 439). We have classified the formalization of inter-organizational partnerships as an outcome of the formalization process, resulting in an organizational structure. We use a dichotomous, categorical definition of formalization, whereby a partnership either has a formal or informal partnership structure. We specifically looked at whether or not two organizations (partnership dyad) shared at
least one type of a formal inter-organizational agreement. Examples of formal agreements included: partnership agreements; memorandum of understanding; affiliation agreements; service agreements; secondment agreements; and strategic alliance agreements; bylaws; and written policies/procedures. The rationale for selecting a dichotomous definition was similar to the rationale proposed by Isett and Provan (2005), who suggest that a contractual tie (written agreement) is a legally enforceable statement about the relationship between two partners.

Administrative collaboration is defined as the combining of the perspectives, knowledge, and skills of diverse partners in a way that allows the partnerships to: “1) think in new and better ways about how it can achieve its goals; 2) plan more comprehensive, integrated programs; and 3) strengthen its relationship to the broader community” (Lasker et al., 2001; Weiss et al., 2002, p. 684). According to Butt et al. (2008), collaboration falls under the theme of interdependency, and is considered one component of the partnership process. Administrative collaboration occurs between two or more individuals who engage in administrative tasks related to the planning, implementation or evaluation of partnership activities. Activities may vary, but do not involve direct patient care.

**Phase II: Online Survey**

During Phase II, an online survey was administered using “Survey Monkey”; an electronic link to the survey was provided to participants via email. The survey had 40 questions (open- and closed-ended questions) and took approximately 10 minutes to complete. The survey contained basic demographic information about each participant and information about the level of administrative collaboration. Participant eligibility criteria: “someone who is familiar with the work of the partnership, as well as its leadership, administration, resources, decision-making processes, and the challenges it faces” (Weiss et al., 2002, p. 686). Staff members in administrative and service delivery roles were eligible to complete the survey, provided they met the above criteria.
Administrative collaboration was assessed using the PSAT (Weiss et al., 2002) subscale ‘partnership synergy’. The PSAT measures the quality of the inter-organizational partnership process. It has demonstrated adequate reliability and validity scores and has been administered within similar populations (Weiss et al., 2002, p. 688; Butt et al., 2008; Browne et al., 2007). Psychometrics of the scales and descriptions of the items of the three sub-scales are reported in detail elsewhere (Browne et al., 2007; Weiss et al., 2002; Lasker et al., 2001). The subscale had 9 items that were scored on a 1-5 Likert scale (extremely well, very well, somewhat well, not so well, and not well at all; scored as 5, 4, 3, 2, 1, respectively; 9 items total). Sample question: “By working together, how well are these partners able to identify new and creative ways to solve problems?” Each individual participant’s score was averaged to yield a composite score between 1 and 5. In instances where data were missing, the average score was calculated using the number of responses provided for each scale. All of the available data provided by participants were included in the analysis.

Phase III: Semi-structured Phone Interviews
Participants in Phase II of the study were recruited to participate in a 45-60 minute phone interview. Selection of participants ensured diversity by formality of the partnership and organizational type. The conceptual framework for the study informed the semi-structured interview guide and questions. The selection of types of interview questions was guided by the typology proposed by Patton (2002). The interview guide contained general questions about the partnership (e.g., partnership description, rationale for the partnership) and open-ended questions about the participants’ experience and partnerships in general, and specific questions about their experiences related to administrative collaboration. The interviews were recorded and transcribed. Interviewees were provided with a small gift certificate in appreciation for their participation.
Data collection and analysis were completed concurrently, providing the flexibility for the researcher to adapt her probes and follow-up questions. Three members of the research team reviewed a small set of the interview transcripts independently, and together, and then worked to narrow and refine the identified themes until agreement was reached. Computer-assisted analysis (e.g., NVivo) was used to help facilitate data storage, coding, retrieval, comparing and linking (Patton, 2002). We analyzed the data concerning: a) the rationale for the partnership; b) mechanisms used to support the partnership; and c) advantages and disadvantages of the formal or informal partnership, in relation to administrative collaboration. Results are presented with distinguishing individual and organizational information removed, to protect the anonymity of the participants.

**Analysis & Results**

**Phase II: Association Between Formalization & Administrative Collaboration**

The total sample size for the Phase II survey was 258 (calculated at the individual staff member level). Of those respondents who provided their demographic information, 80.6% (n=158) reported to be female, and 19.4% (n=38) male (n=62 missing). The average age reported was 45.7 years (SD = 10.3, range 24-68). Fifty-four percent of respondents (n=106) had a university graduate degree, 24.5% (n=48) an undergraduate degree, 19.9% (n=39) a diploma, and 1.5% (n=3) reported that the highest level of education they had was high school (n=62 missing). When asked about their current position, 73 self-identified as an administrator, and 110 identified themselves as a service provider (n=75 missing). In reporting how long respondents have occupied their current position, the mean response was 7.5 years (SD = 7.3; range of 0.8-35.5 years).
**Association Between Formalization & Administrative Collaboration**

We used a t-test to compare means between informal and formal partnerships for level of administrative collaboration. Participants in formal partnerships do not report significantly higher levels of administrative collaboration (see Table 21).

**Table 21: Comparison of Formal & Informal Partnerships on Level of Administrative Collaboration**

<table>
<thead>
<tr>
<th>Administrative Collaboration</th>
<th>Formal (N=90)</th>
<th>Informal (N=168)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.4</td>
<td>3.2</td>
</tr>
<tr>
<td>SD</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Min-Max</td>
<td>1.6-5</td>
<td>1.0-5</td>
</tr>
</tbody>
</table>

Note: An average score of 3-4 on the 5 point scale would be ‘somewhat well to very well’.

**Sub-Group Analysis: Organizational Type & Staff Role**

Comparing the means of administrative collaboration by organizational type (FHTs, CHCs, and MHAs organizations) using a one-way ANOVA showed no significant variation across the organizations. Comparing the means of formal/informal groups for each organizational type using t-tests showed variation in the association between formalization and administrative collaboration (within groups) (see Table 22). CHCs with informal partnership reported significantly higher means for administrative collaboration. MHAs organizations with formal partnerships reported significantly higher means for administrative collaboration.

**Table 22: Comparison of Formal & Informal Partnerships by Organizational Type**

<table>
<thead>
<tr>
<th>Administrative Collaboration</th>
<th>FHTs (N=18)</th>
<th>CHCs (N=24)</th>
<th>MHAs (N=48)</th>
<th>MHAs (N=103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.1</td>
<td>3.2</td>
<td>3.6**</td>
<td>3.2</td>
</tr>
<tr>
<td>SD</td>
<td>0.8</td>
<td>0.8</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Min-Max</td>
<td>1.8-4.7</td>
<td>2.0-4.8</td>
<td>1.9-5.0</td>
<td>1.0-4.4</td>
</tr>
</tbody>
</table>

Note: t-test (*) significant at p < 0.05; (**) significant at p<0.01.
Comparing the means of administrative collaboration by staff role (administrator versus service provider) using a t-test showed significant variation across the two groups (see Table 23). Administrators reported significantly higher means scores on collaboration than did service providers. Comparing the means of formal/informal groups for each staff role using t-tests showed no significant relationship between formalization and level of administrative collaboration (within groups).

<table>
<thead>
<tr>
<th>Administrative Collaboration</th>
<th>Administrators N=73</th>
<th>Service Providers N=110</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.4*</td>
<td>3.2</td>
</tr>
<tr>
<td>SD</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Min-Max</td>
<td>1.4-5</td>
<td>1.1-5</td>
</tr>
</tbody>
</table>

Note: t-test, (*) significant at p < 0.05.

Phase III Interviews: Participant Experiences

Eleven participants from Phase II of the study completed the semi-structured phone interviews. All of the participants were female. All of the participants held an administrative role (e.g., director, clinical director, consultant, and coordinator). Participants were representative of FHTs (n=4), CHCs (n=4), and MHAs (n=3). Four partnerships were informal and seven were formal.

Rationale for Creating the Partnership

Participants were asked to describe the rationale for creating the partnership. Administrators in formal partnerships identified the following rationales: avoid duplication of services; increase access to services; fill in service gaps; improve quality and timing of referrals; shared program delivery; and specific funding requirement. Administrators in informal partnerships identified the following rationales: shared program delivery; increase access to specialized services; increase awareness of illness/disease; community needs; continuity of care; and available funding opportunity.
Participants reported more examples of rational versus relational reasons for engaging in partnerships (e.g., emphasis on exchanges, versus relationships). However, when participants were discussing the rationale for the partnership, they described it within the context of pre-existing relationships (among individuals and organizations). Thus, while the specific examples of reasons for partnering were more rational in nature (e.g., increasing access to services or enhancing continuity of care), there was a relational context in how the partnerships emerged and developed over time (e.g., importance of personal relationships and communications), particularly in informal partnerships.

“[...] I guess it’s very personal to the staff that are in the role. So we have an excellent relationship with that individual, so we are able to speak to them about other potential ideas, and call them for resources for a variety of things. I guess how we build relationships is very much a personal thing, from person to person and agency to agency [...]” (#14, informal, CHC)

**Mechanisms to Support the Partnership**

Participants were asked to describe the processes or steps (mechanisms) that are required to support partnership activities across the two organizations. The mechanisms to support the partnerships that were identified by participants included a range of governance and operational structures and processes, with a greater emphasis on operational processes. Administrators in formal partnership identified the following mechanisms: common patient referral and/or intake process; site visits, co-location or shared work space; shared patient information (e.g., database or follow-up forms); regular communication and meetings; shared governance structure; clear mandate of organizational roles and responsibilities; formalized and shared education/training opportunities; shared marketing of services and promotion of joint programs. Administrators in
informal partnership identified the following mechanisms: regular communication; shared interest and commitment to work together; in person meetings; and shared patient visits.

**Advantages & Disadvantages of Formalization in Relation to Administrative Collaboration**

Participants were asked to describe how the formality of the partnership supports or hinders collaboration and their role in the partnership. Overall, participants reported benefits and drawbacks to both formal and informal partnerships.

*Experiences of administrative collaboration in formal partnerships.* Participants reported that formal partnerships helped to solidify organizational relationships, enhance communication, clarify roles and responsibilities, enhance awareness of services, and have a positive impact on the patient experience.

“I think because we have a formalized partnership, we better understand their program, we understand their weakness and we understand what services they’re providing. We can talk to any of the mental health therapists at any point. I can certainly easily meet with the Director or with the Senior Manager and we can move things fairly quickly because we have that very clearly established relationship already.” (#4, formal, FHT)

“I think having a formal partnership solidifies that relationship, and it certainly strengthens the relationship. And it makes it a more even two-way street, where they can call me if there are concerns, I can call them, we can brainstorm, we can toss ideas around, that kind of thing [...] it solidifies that partnership. So, if I think of who should I reach out to, my partners within a partnership agreement would be who I think of first, as opposed to agencies that are less formalized.” (#15, formal, CHC)
Participants in formal partnerships also expressed frustrations with clarity of the written agreement, additional layers of bureaucracy and red tape, which impact the roles of administrators and service providers.

“[…] it’s a bit cumbersome. It can be difficult to understand the agreement, because of the language that’s used it can be intimidating. […] a lot of community agencies don’t have easy access to a lawyer, or don’t have the funds to pay for a lawyer if they want to have a lawyer to review the document.” (#12, formal, MHA organization)

“[…] decisions that must be made at those levels [administrative] that perhaps aren’t being made, or haven’t been concretely clarified, that act as stumbling blocks, and act to really frustrate our clinicians who are trying to do the best job that they know is clinically appropriate.” (#6, formal, FHT)

Experiences of administrative collaboration in informal partnership. Participants expressed that informal partnerships demonstrated a positive example of community development, shared ownership and commitment to the program, greater flexibility, and enhanced access to services.

“[…] the synergy is such that every individual and organization around the table feels a sense of ownership of that program, is proud of it, wants to see it do well, wants to see it grow and change. […] it’s community development at its best I guess, really, if everybody owns a section of it and will contribute and bring what they can to the table.” (#14, informal, FHT)

“[…] this way, the collaboration is far better for the client because you don’t have to go through all this process. If you have someone you feel is quite urgent, that’s vocalised to them and they expedite things a little more. […] At this point I don’t see where we would
benefit to have it too formalised. I think it might limit access when we needed it.” (#3, informal, FHT)

Participants expressed drawbacks to informal partnerships, including challenges that arise when staff leave (turnover) and or when restructuring occurs, and expressed the importance of having a strategic plan to develop additional stakeholders and continue to foster important relationships.

“I think you need commitment at the organizational level, so not just with the individuals. The danger is when you’re informal, partnership lies with the individual and [if] they haven’t communicated well back to the organization as a whole, that when that person leaves that is fragmented and you have to start from square one [...] you hope that that relationship goes beyond the individual and is sort of embedded into the core of the organization [...] hoping that the organization has some kind of a strategic plan to develop stakeholders and foster those relationships.” (#14, informal, FHT)

**Importance of Organizational Characteristics**

The results of the interviews provide some insights about the organizational characteristics that might influence the association between formalization and administrative collaboration. Key factors that were identified by participants included: organizational size, communication mechanisms, and availability of resources. Our interview questions did not specifically explore the differences experienced by participants according to the type of organization.

“I find whether it’s a formal or informal partnership, when organizations are very large the communication of the importance, and impact, and technicalities of the partnership may not be communicated as effectively throughout the organization [...] When I think it becomes more difficult, particularly with informal partnerships, is when you have bigger
organizations. And that’s where having things more clearly stated can be helpful.” (#9, informal, MHA organization)

“[…] So they’re [partner] very big, and of course they have more resources, in terms of bodies, and they also have a greater population to serve, a more diverse population, than we do. […] I think we need to be aware that, as much as our needs are important, they’ve got a much bigger picture that they need to balance as well, and I think that’s often lost on people […] They’re seen as a big organization and we’re seen as a smaller one, so I mean I think there’s a kind of push and pull, and assumptions sometimes are made about how many resources that we in fact have, and services.” (#6, formal, FHT)

Discussion
This study sought to determine if there is an association between formalization and administrative collaboration, and to explore how aspects of collaboration are experienced by administrators in formal and informal partnerships. By bringing together the quantitative and qualitative findings, possible explanations of the findings and opportunities for future research are provided.

The quantitative findings indicate that participants in formal partnerships do not report higher levels of administrative collaboration compared to those in informal partnerships. While subgroup analysis by organization suggested that the association between formalization and collaboration may be different depending on the type of organization (FHT, CHC, or MHA organization), the differences observed are so small that they may not be practically significant. These findings may be the result of a number of potential factors, including: 1) it is possible that formalization does not enhance collaboration; 2) there may be other factors that mediate or have a direct impact on the relationship between the two variables that we did not measure; or 3) it may
be a measurement issue, and more sophisticated measures of the two variables are required (e.g., measuring formalization on a continuum, rather than categorically).

The qualitative findings provide two contributions to understanding the research problem from the perspective of administrators. First, the results of the interviews may help explain why administrative collaboration was not higher in formalized partnerships, and why differences were not practically significant when compared by organization type. Although there has been a greater emphasis in the literature examining the advantages and disadvantages of formalization (Vlaar et al., 2007b), with less attention given to understanding informal partnerships, our results indicate that administrators experience both advantages and disadvantages of formal and informal partnerships. This suggests that formalization may not offer a distinct benefit over informal partnerships, or that informal partnerships have significant advantages that have not been sufficiently explored in the literature (as they relate to collaboration).

The two groups of participants reported different forms of benefits and drawbacks, which may suggest ways in which formal/informal partnerships may have an impact on collaboration. Administrators in informal partnerships rely heavily on personal relationships and communication between individuals who participate in the partnership. When these relationships are founded on trust, honesty and mutual respect, and communication is open and ongoing, informal partnerships can flexibly and efficiently adapt to patient needs very quickly. However, as expressed by participants, a significant risk occurs when there is staff turnover or organizational restructuring. If informal partnerships do not embed these informal personal relationships and communication activities within other organizational structures or roles, the investment in these important relationships may be lost, and the informal partnership is impacted significantly (e.g., ‘starting over’). These results support previous findings, indicating that formalization is a strategy that facilitates more enduring coordination among organizational partners (Fleury, 2005).
Administrators in formal partnerships benefit from enhanced clarity around roles, responsibilities and accountability, at organizational and staff member levels. This enhanced clarity helps to facilitate relationships and communication, and provides guidance in decision-making and in times of disagreement or lack of clarity (e.g., who is supposed to do what, with whom, and when). However, having a formal agreement does not guarantee that the agreement is clear and understood by all staff members, or that having the agreement (and associated governance or operational mechanisms) in place always enhances collaborative processes. Formalized structures may be necessary unless staff are able to achieve sufficient levels of interaction without formalized support (Nylen, 2007). Future research could explore how the advantages and disadvantages of partnerships directly impact tasks and processes of administrative collaboration (e.g., as measured by the PSAT).

The second contribution of the qualitative analysis is the identification of factors related to the process of creating and/or formalizing partnerships, suggesting that there may be other important factors that mediate or directly impact the relationship between formalization and collaboration, which we did not measure in the current study. For example, interview participants discussed the rationale for creating the partnership, and a variety of mechanisms used to support partnership activities (e.g., governance and operational mechanisms). It is possible that these factors, in addition to the advantages and disadvantages that are experienced by administrators, may influence the relationship between formalization and collaboration. Future research could explore how the rationale and process used to select the level of formalization may influence the mechanisms that are applied to support the partnership and collaboration. In addition, future research could explore how the mechanisms that are applied to support the partnership may influence the advantages and disadvantages that are experienced by staff members.
Limitations
Several limitations of the current study provide opportunity for future research. First, due to practical restrictions of the research study, we did not interview service providers about their experiences with administrative collaboration (although they did complete the Phase II survey), nor were we able to collect data to a point of saturation. This would have provided a more robust assessment of the association between formalization and administrative collaboration. Second, we did not collect organizational demographic data from the MHA organizations (e.g., size, geography, age), which would have provided useful information for further analysis of the results based on organizational type.

Conclusion
Organizations are increasingly encouraged to develop and strengthen community partnerships, yet many struggle with how to create and implement them effectively or efficiently. Formalization of inter-organizational partnerships has been suggested as one type of governance strategy thought to positively influence administrative collaboration. The results of the study suggested that collaboration is not higher in formalized partnerships. Although we observed significant relationships between formalization and collaboration when we compared the results by organizational type, the results may not have practical significance. The qualitative findings help us to interpret the quantitative findings in two ways, and point to future research opportunities. Administrators experience both advantages and disadvantages to formal and informal partnerships, suggesting that formal partnerships may not provide more benefits to enhancing collaboration. In addition, the creation and formalization of partnerships is a process that may involve a series of factors that could mediate or directly impact the association between formalization and collaboration.
Chapter 7 (Paper 3): Association Between Formalization & Service Delivery Collaboration

This Chapter presents Paper #3 of the 3-paper thesis option.

Introduction

Adults with complex mental health and/or addictions needs require services from a range of human service providers and organizations (AOHC, 2008; Boydell et al., 2008; Durbin et al, 2001). In Ontario (Canada), significant restructuring of primary care (Olsen et al., 2007) and the de-institutionalization of mental health and addictions services (Hartford et al., 2003; Wiktorowicz, 2005) have changed the way organizations and serviced providers work together. In response to a history of unmet needs, lack of continuity of care, and insufficient access to services for patients with a range of health needs, there is a move towards increased partnerships among primary care, mental health and addiction service organizations and the implementation of interprofessional, team-based care (Butt et al., 2008; Browne et al., 2007; Suter et al. 2007). This means that service providers must learn to work better together with their colleagues both within and across organizational boundaries. The intention is to reduce costs, improve access to, and the quality of, services and enhance the wellbeing of patients. There is evidence to suggest that collaboration among service providers has a positive impact on patient outcomes (Craven & Bland, 2006; Oandasan et al., 2006; Barrett et al., 2007).

Researchers have suggested that organizational structures such as the formalization of partnerships enhance partnership functioning (Nylen, 2007; Isett & Provan, 2005; Foster & Meinhard, 2002; Lasker et al., 2001), partnership processes (Wiktorowicz et al., 2010; Florin et al., 2000; Fleury, 2005; Kegler et al., 1998; Rogers et al., 1993), and more specifically, service delivery collaboration (Smith & Mogro-Wilson, 2007; Smith & Mogro-Wilson, 2008; Sicotte et al., 2002; D’Amour et al., 2004; San Martin Rodriguez et al., 2005; Fleury, 2005; Lasker et al., 2001; Nylen, 2007).
Formalization, as a governance mechanism, is thought to be advantageous and facilitate service delivery collaboration for several reasons. Sicotte et al. (2002) propose that formalization may impact intra-group processes such as: belief in the benefits associated with collaboration, social integration within groups, level of conflict resulting from collaboration, and work group design characteristics. Formalization of partnerships is also thought to impact decision-making and the ability to preserve procedures that impact how a partnership functions beyond the tenure of any individual staff member (Lasker et al., 2001). At a more interpersonal level, Fleury (2005) proposed that formalization allows for more enduring coordination among partners. Formalized structures may also be necessary unless staff members are able to achieve sufficient levels of interaction (intensity) without formalized support (Nylen, 2007). Overall, there is preliminary support for the positive association between formalized and service delivery collaboration. However, most of the studies to date have been conducted in an intra-organizational setting, and very few have explicitly looked at the impact of formalized organizational structures on service delivery collaboration.

The objectives of the study were to: 1) measure the association between formalization and service delivery collaboration; and 2) explore how aspects of collaboration were experienced by the service providers who work across organizations in both formal and informal partnerships.

Conceptual Foundation

The conceptual foundation for this study resulted from a review of the theoretical and empirical literature, spanning inter-organizational development (Schermerhorn, 1979; Parmigiani & Rivera-Santos, 2011; Sofaer & Myrtle, 1991; Barringer & Harrison, 2000), service integration (Dickinson, 2006; Lasker et al., 2001; Weiss et al., 2002; Butt et al., 2008; Browne et al., 2007), and collaborative practice (D’Amour et al., 2005; San Martin-Rodriguez et al., 2005; Craven & Bland, 2006; Oandasan et al., 2006; Kates et al., 2011; Reeves et al., 2010; HPRAC, 2008; HCC, 2009; Jelphs & Dickinson, 2008).
The literature describing the tensions that are experienced when organizations create, formalize and/or implement partnerships is divided into two perspectives – organizational economics and organizational theory (Parmigiani & Rivera-Santos, 2011; Barringer & Harrison, 2000; Hill and Lynne, 2003; Vlaar et al., 2007b). In organizational economics (or rational choice theories), the theoretical paradigms used to explain the formation of partnerships primarily focus on exchanges or interactions between organizations. Theories sharing this perspective argue that partnerships form when it is more efficient for an organization to conduct activity through a close partner relationship than on its own, or through the market (e.g., transaction cost economics, resource-based view, agency theory). In organizational theory (social choice theories), the theoretical paradigms used to explain the formation of partnerships primarily focus on relationships and shared values (other than exchanges or interactions). Theories sharing this perspective argue that the formation of partnerships is often based upon prior relationships, trust, and histories between the partners (e.g., resource dependence, stakeholder theory, institutional theory, social networks). Organizations form partnerships to gain legitimacy, status or reputation based on their connections, or to reduce dependency and uncertainty. Formalization of partnerships could be used as a strategy to manage the rational and relational tensions for creating the partnership. Formalization may also be used as a strategy to better manage multiple inter-organizational relationships and/or improve organizational performance.

Researchers embracing a more holistic approach to understanding and examining inter-organizational relationships have recommended a blending of both rational and relational perspectives (Barringer & Harrison, 2000; Hill & Lynn, 2003; Parmigiani & Rivera-Santos, 2011), and avoiding deterministic or prescriptive approaches to their research. Partnerships are complex and a variety of perspectives are required to untangle the factors that contribute to organizational
performance. Thus, the conceptual foundation for the current study embraces both rational and relational perspectives and does not apply one specific theoretical paradigm.

**Methods**

This paper is the result of a study on inter-organizational partnerships in the province of Ontario (Canada). The study was comprised of three distinct phases of data collection, with an overall mixed methods study design. Phase I included an environmental scan of the existing inter-organizational partnerships among FHTs, CHCs and community MHA organizations who provide services to adults with complex mental health and/or addiction needs. Phases II and III of the study were conducted concurrently. Phase II examined the association between formalization and collaboration as a staff practice. Phase III explored how the administrators and service providers who work across organizations experienced two different forms of collaboration. The current paper provides a summary of the data collected from Phases II and III specifically focusing on the data related to service delivery collaboration. The data from Phase I, and Phases II and III (related to administrative collaboration) is reported elsewhere. Detailed methods for Phase II and III, including sample size calculation, and sampling strategy are reported elsewhere. Approval for the three phases of research was obtained through the University of Toronto’s Research Ethics Board.

In this paper, the quantitative and qualitative strands are presented separately, each with their own unique questions, data, analysis and inferences. In the discussion section, the two strands are integrated, as the findings are brought together to provide a more in-depth understanding of how formalized partnership structures impact service delivery collaboration, and how these relationships are experienced by the service providers who participate in these partnerships.

**Main Study Variables**

Vlaar et al. (2007b) define formalizations as “the process of codifying and enforcing output and/or behaviour, and its outcomes in the form of contracts, rules and procedures” (p. 439). We
have classified the formalization of inter-organizational partnerships as an outcome of the formalization process, resulting in an organizational structure. We use a dichotomous, categorical definition of formalization, whereby a partnership either has a formal or informal partnership structure. We specifically looked at whether or not two organizations (partnership dyad) shared at least one type of a formal inter-organizational agreement. Examples of formal agreements included: partnership agreements; memorandum of understanding; affiliation agreements; service agreements; secondment agreements; and strategic alliance agreements; bylaws; and written policies/procedures. The rationale for selecting a dichotomous definition was similar to the rationale proposed by Isett and Provan (2005), who suggest that a contractual tie (written agreement) is a legally enforceable statement about the relationship between two partners.

We define service delivery collaboration as “an interprofessional process for communication and decision-making that through the practice of core collaborator competencies, enables the knowledge and skills of care providers from different types of organizations to synergistically influence the patient care provided”. Service delivery collaboration occurs between two or more individuals who engage in the direct delivery of patient care. These staff members may be service providers, or administrators who have dual roles and also provide direct patient care. We developed the definition by bringing together definitions of inter-agency collaboration (Smith et al., 2007, p. 546) (found in the integration literature) and definitions of collaborative practice (Way & Jones, 2000), interprofessional care, and interprofessional collaboration (Oandasan et al., 2006) (found in the collaborative practice literature).

**Phase II: Online Survey**

During Phase II, an online survey was administered using “Survey Monkey”; an electronic link to the survey was provided to participants via email. The survey had 40 questions (open- and closed-ended questions) and took approximately 10 minutes to complete. The survey contained
basic demographic information about each participant and information about service delivery collaboration. *Participant eligibility criteria*: “an individual who interacts with the partner organization to provide services directly to adults seeking access to services across primary care and MHA organizations”. These criteria were provided in an information letter. Eligible participants could include service providers or administrators who have a dual role and provide direct patient care.

Service delivery collaboration was assessed using the CPQ. The CPQ measures level of and satisfaction with collaboration. The CPQ was originally developed and tested by Baggs (1994), and later revised by Way et al. (2001). Only the sub-scale measuring level of service delivery collaboration was administered. One modification was made in the instructions to participants, as they were asked to respond to the questions with respect to their inter-organizational partners and activities. Since 2001, the CPQ has been modified and used in a variety of settings, and has undergone additional reliability and validity testing (Way et al., 2001). The sub-scale measuring collaboration had 9 items that were scored -3 to +3 (7 point Likert scale) (strongly disagree, disagree, somewhat disagree, neutral, somewhat agree, agree, and strongly agree). Sample questions: “My collaborating partners and I: 1) plan together to make decisions about the care for the patients; 2) demonstrate trust in one another’s decision-making ability in making shared decisions about patient care. Each individual participant’s score was averaged to yield a composite score between -3 and +3. In instances where data were missing, the average was calculated using the number of responses provided. All of the available data provided by participants were included in the analysis.

**Phase III: Semi-structured Phone Interviews**

Participants in Phase II of the study were recruited to participate in a 45-60 minute phone interview. Selection of participants ensured diversity by formality of the partnership and
organizational type. The conceptual framework for the study informed the semi-structured interview guide and questions. The selection of types of interview questions was guided by the typology proposed by Patton (2002). The interview guide contained general questions about the partnership (e.g., partnership description, rationale for the partnership), open-ended questions about the participants’ experience and partnerships in general, and specific questions for service providers about their experience with interprofessional collaboration. The interviews were recorded and transcribed. Interviewees were provided with a small gift certificate in appreciation for their participation.

Data collection and analysis were completed concurrently, providing the flexibility for the researcher to adapt her probes and follow-up questions. Three members of the research team reviewed a small set of the interview transcripts independently, and together, worked to narrow and refine the identified themes until agreement was reached. Computer-assisted analysis (e.g., NVivo) was used to help facilitate data storage, coding, retrieval, comparing and linking (Patton, 2002). We reviewed the interview data concerning: a) the rationale for the partnership; b) mechanisms used to support collaboration; and c) advantages and disadvantages of the formal or informal partnership, in relation to service delivery collaboration. Results are presented with distinguishing individual and organizational information removed, to protect the anonymity of the participants.

Analysis & Results

Phase II: Association Between Formalization & Service Delivery Collaboration

The total sample size for the Phase II survey was 258 (calculated at the individual staff member level). Of those respondents who provided their demographic information, 80.6% (n=158) reported being female, and 19.4% (n=38) male (n=62 missing). The average age reported was 45.7 years (SD = 10.3, range 24-68). Fifty-four percent of respondents (n=106) had a university graduate
degree, 24.5% (n=48) an undergraduate degree, 19.9% (n=39) a diploma, and 1.5% (n=3) reported that the highest level of education they had was high school (n=62 missing). When asked about their current position, 73 identified themselves as an administrator, and 110 identified themselves as a service provider (n=75 missing). In reporting how long respondents have occupied their current position, the mean response was 7.5 years (SD = 7.3; range of 0.8-35.5).

**Association Between Formalization & Service Delivery Collaboration**

We used a t-test to compare means between informal and formal partnerships for level of service delivery collaboration. Participants in formal partnerships did not report significantly higher mean scores on level of service delivery collaboration (see Table 24).

<table>
<thead>
<tr>
<th>Service Delivery Collaboration</th>
<th>Formal N=71</th>
<th>Informal N=136</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>SD</td>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td>Min-Max</td>
<td>-3.0-3.0</td>
<td>-3.0-3.0</td>
</tr>
</tbody>
</table>

Note: Score of 0-1 on the 7 point scale (-3 to +3) would be ‘neutral or somewhat agree’.

**Sub-Group Analysis: Organizational Type & Staff Role**

Comparing the means of service delivery collaboration by organizational type (FHTs, CHCs, and MHAs organizations) using a one-way ANOVA showed no significant variation across the organizations. Comparing the means of formal/informal groups for each of the three types of organizations (FHTs, CHCs, and MHAs organizations) using t-tests showed no significant variation in the impact of formalization on level of service delivery collaboration (within groups). Similarly, comparing the means of collaboration by staff role (administrator versus service provider) showed no significant variation across the two groups. Comparing the means of formal/informal groups for each staff role (administrator versus service provider) using t-tests showed no significant variation in the impact of formalization on level of service delivery collaboration (within groups).
Phase III Interviews: Participant Experiences

Nine participants from Phase II of the study completed the semi-structured phone interviews. Seven participants were female and two were male. All of the participants held a service provider role (e.g., community health representative, social worker, mental health worker, mental health clinician, service provider, case manager, nurse). Participants were representative of FHTs (n=1), CHCs (n=2), and MHA organizations (n=6). Three partnerships were formal and six were informal.

Rationale for Creating the Partnership

Participants were asked to describe the rational for creating the partnership. Results indicated that participants identified both rational and relational reasons for the formation of both informal and formal partnerships. Service providers in formal partnerships identified the following rationales: to meet language needs; lack of funding and need to share resources; common patient needs; and geography. Service providers in informal partnerships identified the following rationales: common patients and patient needs; increase access to services or specialized services; increase awareness of services or specialized services; reduce duplication of services; enhance referrals; fill in service gaps; shared mandates; and geography.

Mechanisms to Support Collaboration

Participants were asked to describe the processes or steps that are required to support collaborative activities (at the service delivery level) across the two organizations. The mechanisms to support the partnerships that were identified by participants included a range of governance and operational structures and processes, with a greater emphasis on operational processes. Service providers in formal partnerships identified the following mechanisms: shared patient information; feedback referral forms (follow-up after patient assessments or visits); shared referral process; management meetings; and patient consent forms. Service providers in informal partnerships identified the following mechanisms: feedback referral forms (follow-up after patient assessments
Advantages & Disadvantages of Formalization in Relation to Service Delivery Collaboration

Interview participants were asked to describe how the formal or informal nature of the partnership impacted service delivery collaboration (i.e., their ability to work with other service providers from the partnering organization). Although the interviews focused largely on a single partnership (identified in Phase II of the study), in some interviews, participants provided both perspectives, having participated in both formal and informal partnerships.

*Experiences of service delivery collaboration in formal partnerships.* Participants reported that formal partnerships helped to: clarify roles and responsibilities of service providers and organizations; clarify accountability; and bring together a range of stakeholders.

“[…] there’s some need for the formal structures in partnerships because of the accountability aspect of the roles that we play and the services we provide.” (#10, informal, FHT)

Participants in formal partnerships also expressed frustrations with having more cumbersome intake or referral processes, and the inability of agreements to ensure access to or use of services.

“[…]I think the formal arrangement as it stands, doesn’t really address making sure that all of the providers at the [partner organization] are available or make use of us. There’s nothing really in our job description that says […] ‘make sure you use the [partner] providers’. I think it’s up to every individual in terms of their work and in terms of best practices, to know that this is something available and that it’s in our interest and the clients’ best interest to use this service.” (#2, formal, CHC)
“[…] it [formality of partnership] puts up roadblocks. […] They [patients] all have to go through the process of being referred there for a centralized intake … in the past, it was a referral came in, a doc could phone me and say, ’I have so-and-so in my office, they’re going through these kinds of issues and struggles, is it possible for me to send them over to meet with you?’ […] process wise, it’s gotten much more difficult.” (#19, formal, MHA organization)

Experiences of service delivery collaboration in informal partnerships. Participants expressed that informal partnerships allow for open and spontaneous communication, provide flexibility in how and when services are provided, and enhance the ability to respond to patient needs more quickly.

“[…] I think the benefits for the informal partnership that I’ve noticed are certainly the relationships you have with the individuals. And the open, more spontaneous conversations and communications that take place without the confines of a boardroom or committee time and schedule, or without the constraints of a book full of procedures and rules, and protocols. […] we can get to work far more quickly on what needs to be done […] in the most expedient, and professional, and beneficial manner.” (#11, informal, MHA organization)

“[…] it allows some flexibility in terms of how we’re going to work together, as well as in terms of what we’re going to work on together.” (#8, informal, MHA organization)

Participants expressed drawbacks to informal partnerships, including a lack of clarity of expectations, roles or responsibilities, and a lack of clarity of accountability.
“[...] it would work better if the communication were clearer in terms of what was actually expected, as opposed to ‘just go and build this relationship and see what comes of it’.” (#8, informal, MHA organization)

Participants compare their experiences with formal and informal partnerships. Many participants, when responding about their experiences with formal and informal partnerships more generally, were able to identify advantages to each type of partnership.

“I think benefit wise, to me they’re almost 50/50 or fairly equal. Again, because you know there is a need for structure and formal relationships just so people – you know, our roles and stuff are very clearly and well defined, not only from a community standpoint, but from a Ministry standpoint, and professional standpoint as well. But I think on an informal level [...] we all play an important role and our services and our experiences are just as important [and] valuable as the next person’s.” (#10, informal, FHT)

“I think a formal partnership is beneficial in that you are very aware of your obligations to each other and what each of your roles is. [...] informal relationships make a big difference when you’re on the ground and running. [...] knowing who you can talk to that will get you the resources you need makes your job on the front line a lot easier. [...] I think formal relationships have a role in getting the funding and the resources and the partnerships in place. But I think the informal relationships are probably really what actually often gets the work done.” (#18, informal, MHA organization)

Discussion
This study sought to determine if there is an association between formalization and service delivery collaboration, and to explore how aspects of service delivery collaboration are experienced by service providers in formal and informal partnerships. By bringing together the quantitative and
qualitative findings, possible explanations of the findings and opportunities for future research are provided.

The quantitative findings indicate that participants in formal partnerships do not report higher levels of collaboration compared to those in informal partnerships. This finding may be the result of a number of potential factors, including: 1) it is possible that formalization does not enhance collaboration; 2) there may be other factors that mediate or have a direct impact on the relationship between the two variables that we did not measure; or 3) it may be a measurement issue, and more sophisticated measures of the two variables are required (e.g., measuring formalization on a continuum, rather than categorically).

The qualitative findings provide two contributions to understanding the research problem from the perspective of service providers. First, the results of the interviews may help explain why service delivery collaboration was not higher in formalized partnerships. Although there has been a greater emphasis in the literature examining the advantages and disadvantages of formalization (Vlaar et al., 2007b), with less attention given to understanding informal partnerships, our results indicate that administrators experience both advantages and disadvantages of formal and informal partnerships. This suggests that formalization may not offer a distinct benefit over informal partnerships, or that informal partnerships have significant advantages that have not been sufficiently explored in the literature (as they relate to collaboration).

Formalization has been identified as a structural characteristic that influences specific service delivery processes (e.g., formalization of care activity procedures, formalization of the assessment of quality of care), and may impact a series of key intra-group processes, which in turn influence levels or intensity of service delivery collaboration (Sicotte et al., 2002). Service providers from both formal and informal groups perceived both advantages and disadvantages associated with formal and informal partnerships. Generally, participants felt that formal and informal
partnerships impact their roles fairly equally, but in different ways. Formal partnerships are beneficial because they help to clarify important aspects of service delivery collaboration (e.g., roles, responsibilities, accountability), similar to the results reported by Smith and Mogro-Wilson (2007). However, informal partnerships are founded on relationships and the ability of service providers to have open, honest and trusting communication with individuals they trust and have mutual respect for. Participants felt that formal structures may be most helpful during the early stages of a partnership, but in the long term, informal partnerships (and strong inter-personal relationships) are what maintain the partnership, provided the intensity of the informal relationships is sufficient (Nylen, 2007). Future research could explore how the advantages and disadvantages of partnerships directly impact tasks and processes of service delivery collaboration (e.g., as measured by the CPQ).

The second contribution of the qualitative analysis is the identification of factors related to the process of creating and/or formalizing partnerships, suggesting that there may be other important factors that mediate or directly impact the relationship between formalization and collaboration, which we did not measure in the current study. For example, interview participants discussed the rationale for creating the partnership, and a variety of mechanisms used to support partnership activities (e.g., governance and operational mechanisms). It is possible that these factors, in addition to the advantages and disadvantages that are experienced by service providers, may influence the relationship between formalization and collaboration. Future research could explore how the rationale and process used to select the level of formalization may influence the mechanisms that are applied to support the partnership and collaboration. In addition, future research could explore how the mechanisms that are applied to support the partnership may influence the advantages and disadvantages that are experienced by service providers.
Limitations
Several limitations of the current study provide opportunity for future research. First, the CPQ was not originally developed or tested within an inter-organizational context. It is possible that the tasks and processes of collaboration are similar in intra- and inter-organizational contexts, but slightly different constructs that require more distinct measurement. Further analysis of the CPQ within this context would contribute to its generalizability. Second, the study did not control for program characteristics, organizational factors or systemic factors, which previous researchers have suggested may be mediating factors in explaining service delivery collaboration in an intra-organizational context (Sicotte et al., 2002). Finally, due to practical restrictions of the research study, we were unable to collect interview data to a point of saturation, which would have provided a more robust assessment of the association between formalization and service delivery collaboration.

Conclusion
Organizations are increasingly encouraged to develop and strengthen community partnerships, yet many struggle with how to enhance collaboration among service providers. Formalization of inter-organizational partnerships has been suggested as one type of governance strategy thought to positively influence service delivery collaboration. The results of the study suggested that collaboration is not higher in formalized partnerships. The qualitative findings help us to interpret the quantitative findings in two ways, and point to future research opportunities. Service providers experience both advantages and disadvantages to formal and informal partnerships, suggesting that formal partnerships may not provide more benefits to enhancing collaboration. In addition, the creation and formalization of partnerships is a process that may involve a series of factors that could mediate or directly impact the association between formalization and collaboration.
Chapter 8: Discussion & Conclusion

Overview
The objectives of this study were to describe the organizational partnerships among FHTs, CHCs and MHA organizations in Ontario (Canada), and to better understand the association between the formalization of inter-organizational partnerships and collaboration as a staff practice. We focused on partnerships that provide services to adults with complex mental health and/or addiction needs. This study provides important theoretical and empirical contributions to the fields of inter-organizational development, service integration and collaborative practice. Opportunities for future research and practical implications are provided.

Partnership Activities in Ontario
The objective of Phase I of the study was to conduct an environmental scan of the existing partnerships between FHTs and CHCs and their MHA organization partners from across Ontario. In total, we identified 513 partnerships across 69 FHTs and 39 CHCs. We restricted the study to partnerships that have a shared focus on providing services to adults with complex mental health and/or addiction needs, and not the full range of partnerships that serve the MHA population. Thus, the number of total existing partnerships that FHTs and CHCs have with MHA organizations is likely underreported (e.g., we did not include partnerships that target children/youth, seniors, women, families, or specific illnesses). We did not examine partnerships between FHTs and CHCs, which is an opportunity for future research, since FHTs and CHCs may access each other for services to support this population.

Most FHTs and CHCs have between 1-3 partnerships with MHA organizations. The majority of these partnerships are informal (80.8% informal versus 19.2% formal) and have existed for less than 5 years (69%). Proportionally, CHCs have more formal partnerships than FHTs (33.3% compared to 9.6%), which is not surprising since FHTs are relatively new, and identifying partners and
developing formalized agreements require time. These general findings are consistent with previous reports (AOHC, 2008; Polivka et al., 2001), and are not surprising given the increased emphasis from the MOHLTC and LHINs on developing community partnerships, as the importance of primary care services and community-based MHA services are underscored.

Beyond the descriptive characteristics of the existing partnerships, two additional findings are relevant as they provide insights that may be considered when conducting future research. First, since FHTs were established in 2005, it is of interest to note that 10.8% (n=31) of the organizational partnerships identified by FHTs were created prior to 2004. This suggests that staff members perceive that pre-existing organizational partnerships were carried forward when FHTs were created, a finding consistent with a recent study (Sherman et al., 2010). We did not collect data about the formation of FHTs to ascertain if the FHTs were a transformation of previously formal organizations, or the creation of a new organization, or if the 31 partnerships were formal or informal. Regardless, individuals within FHTs perceive that the organizational partnerships they had prior to becoming a FHT still existed. This may have implications for staff turnover and organizational restructuring (e.g., do informal partnerships leave with an individual and/or do they manage to stay embedded within an organization?).

Second, when we asked Phase I participants to identify up to 3 organizational partnerships (or the 3 most significant partnerships), our results suggested that specialized MHA programs within hospitals and other community agencies were commonly reported, in addition to community MHA organizations cited in online registries. Thus, we expanded our definition of MHA organizations to include these forms of specialized programs as organizational partnerships. Future research might consider how partnerships with these specialized programs are the same or different than those with community MHA organizations. For example, we assumed that a specialized MHA program in a large hospital would function similar to a community based MHA organization, despite being located
within a larger organization. This may be accurate in terms of the program structure and processes. However, there may be organizational culture influences, or other organizational characteristics that could influence the experience of staff members and patients.

**The Association Between Formalization and Collaboration**

The objective of Phase II of the study was to examine the association between formalization and collaboration as a staff practice. The objective of Phase III of the study was to explore how aspects of administrative collaboration and service delivery collaboration are experienced by staff members who participate in formal and informal partnerships.

Previous research has suggested that formalized inter-organizational structures may enhance levels of administrative collaboration (Kegler et al., 1998; Rogers et al., 1993; Florin et al., 2000; D’Amour et al., 2004; Sicotte et al., 2002; Fleury, 2005; Fleury et al., 2004; Wiktorowicz et al., 2010) and service delivery collaboration (Smith & Mogro-Wilson, 2007; Smith & Mogro-Wilson, 2008; Sicotte et al., 2002; D’Amour et al., 2004; San Martin Rodriguez et al., 2005; Fleury, 2005; Lasker et al., 2001; Nylen, 2007). At an administrative level, formalization of partnership structures may help: clarify the coordination and communication mechanisms across organizations; outline the resources required to support the partnership; determine decision-making processes, accountability mechanisms, or liabilities; and clarify the roles and responsibilities for each of the organizational partners and the staff. At a service delivery level, formalization of partnership structures may help: facilitate the communication among staff across organizations (e.g., sharing of patient information); provide the structure needed to facilitate the intensity or frequency of interactions among staff; and clarify the roles and responsibilities for service providers.

Based on the quantitative results from Phase II of the study (presented in Papers 2 and 3), the following main study findings were observed:
1. **Administrative Collaboration**: Results showed *no significant* relationship between formalization and administrative collaboration, overall.
   a. Results showed *no significant* differences in level of administrative collaboration when compared across the three organizational types. Results showed *significant* variation in the relationship between formalization and administrative collaboration when compared by *organizational type* (within group comparison), although the results may not be practically significant.
   b. Results showed *significant* differences in the level of administrative collaboration when compared by *staff role*, although the results may not be practically significant. Results showed *no significant* variation in the relationship between formalization and administrative collaboration when compared by staff role (within group comparison).

2. **Service Delivery Collaboration**: Results showed *no significant* relationship with service delivery collaboration, overall.
   a. Results showed *no significant* differences in level of service delivery collaboration when compared across the three organizational types. Results showed *no significant* variation in the relationship between formalization and service delivery collaboration when compared by organizational type (within group comparison).
   b. Results showed *no significant* differences in level of service delivery collaboration when compared by staff role. Results showed *no significant* variation in the relationship between formalization and service delivery collaboration when compared by staff role (within group comparison).
Overall, the quantitative findings indicate that staff members who are part of formalized inter-organizational partnerships do not report higher levels of administrative or service delivery collaboration, compared with staff members who are part of informal inter-organizational partnerships. These findings may be the result of a number of potential factors, including: 1) it is possible that formalization does not enhance collaboration; 2) there may be other factors that mediate or have a direct impact on the relationship between the variables that we did not measure; or 3) it may be a measurement issue, and more sophisticated measures of the variables are required (e.g., measuring formalization on a continuum, rather than categorically).

The qualitative findings provide two contributions to understanding the research problem from the perspective of administrators and service providers. First, the results of the interviews may help explain why collaboration was not higher in formalized partnerships. Although there has been a greater emphasis in the literature examining the advantages and disadvantages of formalization (Vlaar et al., 2007b), with less attention given to understanding informal partnerships, our results indicate that administrators and service providers experience both advantages and disadvantages of formal and informal partnerships. This suggests that formalization may not offer a distinct benefit over informal partnerships, or that informal partnerships have significant advantages that have not been sufficiently explored in the literature (as they relate to collaboration).

The second contribution of the qualitative analysis is the identification of factors related to the process of creating and/or formalizing partnerships, suggesting that there may be other important factors that mediate the relationship between formalization and collaboration, which we did not measure in the current study. For example, interview participants discussed the rationale for creating the partnership, and a variety of mechanisms used to support partnership activities (e.g., governance and operational mechanisms). It is possible that these factors, in addition to the
advantages and disadvantages that are experienced by administrators and service providers, may influence the relationship between formalization and collaboration.

In the following section, we build upon the conceptual foundation for the study, previous research (crossing three bodies of literature, including inter-organizational development, service integration and collaborative practice), and our empirical results to propose a pathway through which formalization may be associated with administrative and service delivery collaboration.

**Expanding the Theoretical Foundation: The Association Between Formalization & Collaboration**

We propose the reason why formalization may be associated with collaboration is a function of: 1) the rationale for the partnership and the process used to determine the level of formalization of the partnerships; 2) the mechanism(s) selected and applied to support the partnership and collaboration; and 3) the resulting effects of formalization (advantages and disadvantages) that are experienced by staff members (see Figure 5).

The proposed pathway expands the dialectic perspective on the decision-making process in formalizing inter-organizational relationships developed by Vlaar et al. (2007b) in three ways. First, the pathway includes possible governance and operational mechanisms that are selected and applied to support the partnership and collaboration (building upon the work by Hill and Lynn, 2003). Second, we expand the advantages and disadvantages experienced by staff to include formal and informal partnerships. Third, we propose that the advantages and disadvantages experienced by staff influence the perceived level of collaboration.
The pathway emphasizes the following: 1) both rational and relational theoretical perspectives influence the decision-making process (rationale) to select the level or type of formalization (Vlaar et al., 2007b); 2) the mechanisms that are selected to support the level of formalization might include both rational and relational governance (Hill & Lynn, 2003) and operational mechanisms; 3) staff members experience a combination of advantages and disadvantages associated with the level or type of formalization (Vlaar et al., 2007b) and mechanisms applied; and 4) these advantages and disadvantages influence the level of collaboration among staff members. Our theoretical approach aligns with the dialectic perspective on the formalization of IORs proposed by Vlaar et al. (2007b), and its four principles (simultaneity; locality; minimality; and generality). Figure 6 illustrates the proposed pathway in more detail.
**Figure 6: Proposed Pathway Through Which Formalization may be Associated with Collaboration**

<table>
<thead>
<tr>
<th>Rationale &amp; decision process to select level of formalization</th>
<th>Mechanisms to support the partnership &amp; collaboration</th>
<th>Advantages / disadvantages experienced by staff members</th>
<th>Level of collaboration as a staff practice (tasks &amp; processes affected)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rational Perspectives &amp; Tensions</strong></td>
<td><strong>Rational Mechanisms</strong> Governance examples  - Centralized functional administration  - Financial contracts that have provisions for fund transfers and reallocations  - Operational examples  - Common intake form  - Site visits</td>
<td><strong>Advantages</strong>  - Coordination  - Control  - Legitimacy  - Cognition and learning <strong>Disadvantages</strong>  - Inhibiting  - Reducing  - Driving out  - Inducing Risk  - Imposing  - Creating Conditions</td>
<td><strong>Administrative Collaboration</strong> (PSAT; Weiss et al., 2002)  - Identify new and creative ways to solve problems  - Include the views and priorities of the people affected by the partnership’s work  - Develop goals that are widely understood and supported among partners  - Identify how different services and programs in the community relate to the problems the partnership is trying to address  - Respond to the needs and problems of the community  - Implement strategies that are most likely to work in the community  - Obtain support from individuals and organizations in the community that can either block the partnership’s plans or help move them forward  - Carry out comprehensive activities that connect multiple services, programs, or systems  - Clearly communicate to people in the community how the partnership’s actions will address problems that are important to them</td>
</tr>
<tr>
<td><strong>Relational Perspectives &amp; Tensions</strong></td>
<td><strong>Relational Mechanisms</strong> Governance examples  - Temporary personnel reassignments  - Shared human capital or physical assets  - Alliances and partnerships based on shared values  - Operational examples  - Referral processes  - Regular communication</td>
<td></td>
<td><strong>Service Delivery Collaboration</strong> (CPQ; Way et al., 2001)  - Plan together to make decisions about the care for the patients (when appropriate)  - Communicate openly as decisions are made about patient care  - Share responsibility for decisions made about patient care  - Co-operate in making decisions about patient care  - Co-ordinate implementation of a shared plan for patient care  - Demonstrate trust in one another’s decision-making ability in making shared decisions about patient care  - Respect one another’s knowledge and skills in making shared decisions about patient care  - Fully collaborate in making shared decisions about patient care</td>
</tr>
<tr>
<td>Factors:  - The manager’s knowledge and past experience with formalization,  - The characteristics of the organization (firm factors)  - The rationale for engaging in a partnership (transaction factors)  - The environmental context (contextual factors)</td>
<td>Governance examples</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To further expand this discussion, in each of the following sub-sections we review the main research findings for each component of the proposed pathway, identify new observations as we compare administrative and service delivery collaboration, and provide a series of propositions and possible research questions to guide further investigation.

**Selecting the Level of Formalization: The Rationale for Creating the Partnership**

Why and how the formalization of partnerships occurs is a relatively complex decision-making process. Two theoretical perspectives propose why organizations create partnerships: perspectives that view IORs as exchanges (traditional view; organizational economics) versus those that view IORs as social relationships (a more modern view; organizational theory). Organizational leaders likely engage in partnerships to benefit both from exchanges and social relationships, in an attempt to improve organizational performance. In addition, organizational leaders engage simultaneously in both co-exploration and co-exploitation activities. This tension is affected by the rationale for creating an IOR, and influences the form of the IOR selected (or combinations of IORs selected, since many organizations engage in multiple and simultaneous relationships). Thus, in selecting the level of formalization of partnerships, decision-makers are also influenced by the tensions to: a) benefit from exchanges and social relationships; and b) create new knowledge, tasks or functions (focus on innovation), while also executing existing knowledge, tasks or functions (focus on expansion).

The process used to determine the level of formalization that is employed in an organization may involve organizational and individual factors, which influence managerial choice. Four factors that have been identified include: (1) the manager’s knowledge and past experience with formalization, (2) the characteristics of the organization (firm factors), (3) the rationale for engaging in a partnership (transaction factors), and (4) the environmental context (contextual factors) (Vlaar et al., 2007b). In addition, Vlaar et al. propose that managers are also influenced both by the need
and ability to formalize IORs. Formalization of IORs may also be emergent or imposed. In the context of the current study, we conceptualize a ‘manager’ as an individual who has the decision-making authority or responsibility to determine the level of formalization of a partnership, and we acknowledge that more than one individual may be involved in, or influence the decision (e.g., organizational leader, decision-maker, manager).

We compared the rationales for creating the partnerships, reported by administrators and service providers, and also by formal and informal groups (see Table 25). We did not collect quantitative or qualitative data specific to the other three factors identified by Vlaar et al. (2007b). We do not propose that the examples collected from participants are exhaustive of the possible rationales for creating formal or informal partnerships. In addition, we did not collect data from administrators and service providers from the same partnership; thus, we are not interested in comparing whether or not there was agreement between responses within partnerships. These are all areas for consideration in future research.

The following questions are of interest:

- Are there examples of rational and/or relational reasons for creating the partnerships?
- Are there examples of efforts to engage in co-exploration and/or co-exploitation activities?
- Do administrators and service providers identify similar rationales for formal partnerships?
  What about their responses for informal partnerships?
- Do administrators in formal and informal partnerships report similar or different rationales for creating the partnership? What about responses provided by service providers?
### Table 25: Comparison of Rationales for Creating the Partnership

<table>
<thead>
<tr>
<th>Rationales Reported by Administrators</th>
<th>Rationales Reported by Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal</td>
<td></td>
</tr>
<tr>
<td>• avoid duplication of services</td>
<td>• to meet patient needs</td>
</tr>
<tr>
<td>• increase access to services</td>
<td>• lack of funding and need to share</td>
</tr>
<tr>
<td>• fill in service gaps</td>
<td>resources</td>
</tr>
<tr>
<td>• improve quality and timing of</td>
<td>• common patient needs</td>
</tr>
<tr>
<td>referrals</td>
<td>• geography</td>
</tr>
<tr>
<td>• shared program delivery</td>
<td></td>
</tr>
<tr>
<td>• specific funding requirement</td>
<td></td>
</tr>
<tr>
<td>Informal</td>
<td></td>
</tr>
<tr>
<td>• shared program delivery</td>
<td>• common patients and patient needs</td>
</tr>
<tr>
<td>• increase access to specialized</td>
<td>• increase access to services</td>
</tr>
<tr>
<td>services</td>
<td>• increase awareness of services</td>
</tr>
<tr>
<td>• increase awareness of illness/disease</td>
<td>• reduce duplication of services</td>
</tr>
<tr>
<td>• community needs</td>
<td>• enhance referrals</td>
</tr>
<tr>
<td>• continuity of care</td>
<td>• fill in service gaps</td>
</tr>
<tr>
<td>• available funding opportunity</td>
<td>• shared mandates</td>
</tr>
<tr>
<td></td>
<td>• geography</td>
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</tbody>
</table>

The first observation is that both administrators and service providers are knowledgeable about the rational for creating both formal and informal partnerships. That is, we did not observe a lack of awareness in either group. This suggests a number of important considerations about how staff members come to know about the rationale for the partnership: 1) the staff member may be involved in the decision-making process; and 2) there are communication mechanisms that facilitate the sharing of information about the rationale for the partnership.

Second, administrators and service providers identify rational (exchanges) and relational (relationships) perspectives in describing the reason for creating the partnership. Examples of rational reasons include: fill in service gaps; available funding opportunity; lack of funding and need to share resources. Examples of relational reasons include: improve the quality and timing of referrals; common patient needs; and increase awareness of services.
Third, administrators and service providers provide evidence of the engagement in both co-exploration (innovation) (e.g., shared program delivery) and co-exploitation (expansion) (e.g., enhancing awareness or access to services, improve quality and timing of referrals) activities as part of the rationale for the partnership.

Fourth, administrators and service providers did not appear to report similar reasons for engaging in the formal partnership. Although, this does not necessarily mean that there is not any overlap. Administrators and service providers in informal partnerships both identified increasing access to services and increasing awareness as reasons for creating the partnership. Thus, there is some evidence to suggest that regardless of staff role, there may be overlap in the perceptions for the rationale for creating partnerships.

Finally, when we compared the responses of administrators of formal and informal partnerships, we observe some overlap, related to increasing access to services and funding. Comparing the responses for service providers, there was overlap related to patient needs and geography. Thus, formal and informal partnerships may be created for similar reasons, as perceived by both administrators and service providers.

As a result of the above preliminary observations, a series of propositions and corresponding research questions are provided for the consideration of future research in this area.

**Proposition 1: More than one individual may be involved in the decision-making process that determines the rationale for the partnership and the level of formalization of a partnership.**

**RQ 1:** Who are the individuals involved in the rationale for the partnership?

**RQ 2:** Who are the individuals involved in determining the level of formalization of a partnership?
RQ 3: What is the past knowledge and experience of these individuals with formal versus informal partnerships?

RQ 4: What does the decision-making process look like? (e.g., who is involved, what is discussed)

Proposition 2: The rationales for creating formal versus informal partnerships may be similar. Both formal and informal partnerships may be considered useful in achieving common objectives (e.g., increasing access to services).

RQ 1: What are the most likely reasons to create a formal partnership?

RQ 2: What are the most likely reasons to create an informal partnership?

RQ 3: If the objective is the same, why do some organizations formalize a partnership, while others do not?

Mechanisms that Support the Partnership & Collaboration

Examples of both rational and relational forms of mechanisms used to support IORs (including partnerships) have been identified in the literature (Hill & Lynn, 2003). We propose that the selection of mechanisms is influenced by the rationale for the partnership and the decision-making process to select the level or type of formalization of a partnership. Mechanisms are selected and implemented in order to support the partnership and collaboration among staff members.

We compared the mechanisms reported by administrators and service providers in both formal and informal partnerships. We do not propose that the examples collected from participants are exhaustive of the possible mechanisms that are implemented to support the partnership and collaboration. Since we did not collect data from administrators and service providers from the same partnership, we are not able to compare whether or not there was agreement between responses within partnerships. These are all areas for consideration in future research. In addition,
we included findings from Phase I of the study about the administrative and service delivery ties that are included in formal inter-organizational partnership agreements between FHTs and MHA organizations, and CHCs and MHA organizations. We did not ask respondents to report administrative or service delivery ties that are part of their informal partnerships, which is an opportunity for future research.

The following questions are of interest:

- What types of mechanisms are reported by participants? (e.g., governance or operational)
- Are there examples of rational and/or relational mechanisms for each type of mechanism identified?
- Do administrators in formal and informal partnerships report similar or different mechanisms to support partnership activities?
- Do service providers in formal and informal partnerships report similar or different mechanisms to support service delivery collaboration?
- Are there examples of rational and/or relational mechanisms (e.g., governance or operational) included in formal inter-organizational agreements?

In Phase I of the study, we asked respondents to identify the administrative and service delivery ties that are included in their formal inter-organizational agreements. Administrative service delivery ties included: shared resources, shared human resources, inter-agency meetings, shared administrative information, administrative coordination/governance structure, and shared financial resources. Shared resources and shared human resources were the service ties most frequently reported by FHTs and CHCs. Service delivery ties included: joint services (e.g. service referrals, received/sent), shared patient/client information, joint consultations, case coordination, co-location

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of providers, joint programs in mental health and/or addictions, common intake and/or assessment forms, and common management system. The most common service delivery ties reported by FHTs and CHCs were joint services and shared patient/client information.

In Phase III of the study, we asked interview participants to either describe the processes or steps that are required to support the partnership activities (administrators) or the collaborative activities (service providers), across the partnering organizations. We have summarized the responses collected, and compared them for formal and informal partnerships (see Table 26).

Table 26: Comparison of Mechanisms that Support the Partnership & Collaboration

<table>
<thead>
<tr>
<th>Mechanisms Reported by Administrators</th>
<th>Mechanisms Reported by Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal</strong></td>
<td></td>
</tr>
<tr>
<td>• common patient referral and/or intake process</td>
<td>• shared patient information</td>
</tr>
<tr>
<td>• site visits or co-location or shared work space</td>
<td>• feedback referral forms</td>
</tr>
<tr>
<td>• shared patient information (e.g., database or follow-up forms)</td>
<td>• shared referral process</td>
</tr>
<tr>
<td>• regular communication and meetings</td>
<td>• management meetings</td>
</tr>
<tr>
<td>• shared governance structure</td>
<td>• patient consent forms</td>
</tr>
<tr>
<td>• clear mandate of organizational roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td>• formalized and shared education/training opportunities</td>
<td></td>
</tr>
<tr>
<td>• shared marketing of services and promotion of joint programs</td>
<td></td>
</tr>
<tr>
<td><strong>Informal</strong></td>
<td></td>
</tr>
<tr>
<td>• regular communication</td>
<td>• feedback referral forms</td>
</tr>
<tr>
<td>• shared interest and commitment to work together</td>
<td>• co-location</td>
</tr>
<tr>
<td>• in person meetings</td>
<td>• communication and shared respect</td>
</tr>
<tr>
<td>• shared patient visits</td>
<td>• meetings to discuss roles and mandates at organizational level</td>
</tr>
</tbody>
</table>

The first observation is that both rational and relational mechanisms are identified by the participants who completed the Phase I survey, and the administrators and service providers...
interviewed in Phase III. Second, regular communication and meetings was one example of a mechanism that was reported by administrators in both formal and informal partnerships. Third, service providers in formal and informal partnerships both identified the following mechanisms in supporting service delivery collaboration: feedback referral forms; and shared referral process. Thus, our observations confirm that both rational and relational mechanisms are identified by study participants, and there is some overlap in the mechanisms identified by staff role, and by level of formalization.

As a result of the above preliminary observations, a series of propositions and corresponding research questions are provided for the consideration of future research in this area.

Proposition 3: the type of mechanisms selected and implemented by managers will be influenced by the decision-making process used to select the level of formalization.

RQ 1: How do managers determine the type of mechanisms they apply? How do they address the relational/rationale, and co-exploration/co-exploitation tensions they experience?

RQ 2: If the rationale for creating a partnership is rational in nature, are managers more likely to select mechanisms that are also rational in nature?

RQ 3: If the rationale for creating a partnership is relational in nature, are managers more likely to select mechanisms that are also relational in nature?

Proposition 4: the type of mechanisms selected by managers will vary, making each partnership structure and corresponding processes unique.

RQ 1: Do managers in formal and informal partnerships employ similar or different types of governance mechanisms?

RQ 2: Do managers in formal and informal partnerships employ similar or different types of operational mechanisms?
RQ 3: Do formal and informal partnerships enforce their mechanisms differently?

Advantages & Disadvantages of Formalization in Relation to Collaboration

In the review of the literature (Chapter 2), we identified advantages and disadvantages with creating IORs in general (Barringer & Harrison, 2000), and more specifically, with formalizing IORs (Vlaar et al., 2007b). Generally, functions (advantages) of formalization are considered consequences that change an organization’s existing context or condition in the direction towards desired objectives, and dysfunctions (disadvantages) of formalization contribute the opposite effect (Vlaar et al., 2007b). We propose that these advantages and disadvantages are experienced by administrators and service providers engaged in formal and informal partnerships. In addition, we propose that the degree to which staff members experience advantages over disadvantages influences the level of collaboration.

We compared the advantages and disadvantages reported by administrators and service providers in both formal and informal partnerships. We do not propose that the examples collected from participants are exhaustive of their experiences. It is also important to note that we asked administrators and service providers different questions. Administrators were asked to describe how the formality of the partnership supports or hinders administrative collaboration and their role in the partnership. Service providers were asked to describe how the formal or informal nature of the partnership impacted service delivery collaboration (i.e., their ability to work with other service providers from the partnering organization).

The following questions are of interest:

- Is there overlap among the advantages reported in the literature and those reported by administrators and/or service providers?
• Is there overlap among the disadvantages reported in the literature and those reported by administrators and/or service providers?

• Is there overlap among the advantages reported by administrators and service providers?

• Is there overlap among the disadvantages reported by administrators and service providers?

To be able to explore this in more depth, we present the advantages and disadvantages reported in the literature (general to IORs and specific to formalization), with those reported by Phase III study participants (administrators and service providers) engaged in formal and informal partnerships (see Table 27).

The first observation is that there is some overlap in the advantages reported in the literature and those reported by our Phase III participants. For example, we see similarities in economies of scale (e.g., access to services, flexibility in how and when services are provided) and coordination (e.g., clarity of roles and responsibilities, and communication).

Second, there is some overlap in the disadvantages reported in the literature and those reported by our Phase III participants. For example, we see similarities in management complexities (e.g., bureaucracy and red tape) and the inhibition of flexibility (e.g., cumbersome intake or referral processes).

Third, the advantage termed ‘awareness of services’ was shared by administrators and service providers in formal partnerships. Flexibility was an advantage shared by administrators and service providers in informal partnerships. Thus, there is some evidence to suggest that the advantages experienced by administrators and service providers may be similar, despite the fact that the tasks and processes they engage in are different (relative to administrative versus service delivery collaboration).
Fourth, administrators and service providers in formal partnerships both identified frustrations related to bureaucracy/red tape (e.g., cumbersome intake or referral processes), and the lack of clarity of the written agreement. Given the responses that were provided, there did not appear to be direct overlap in the disadvantages reported by administrators and service providers in informal partnerships.

As a result of the above preliminary observations, a series of propositions and corresponding research questions are provided for the consideration of future research in this area.

**Proposition 5: Informal partnerships have advantages and disadvantages that will influence the experience of staff members.**

RQ 1: What are the most common advantages and disadvantages associated with informal partnerships?

RQ 2: Are the advantages and disadvantages of formal and informal partnerships similar?

**Proposition 6: The type of mechanisms selected by managers will influence the advantages and disadvantages of formalization experienced by staff members.**

RQ 1: What are the advantages and disadvantages associated with governance mechanisms?

RQ 2: What are the advantages and disadvantages associated with operational mechanisms?

RQ 3: Does the number of mechanisms influence perceptions of advantages or disadvantages?
## Table 27: Comparing Advantages & Disadvantages of IORs

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Participating in IOR*</th>
<th>Formalizing an IOR**</th>
<th>Administrators***</th>
<th>Service Providers***</th>
</tr>
</thead>
</table>
| **Advantages** | • Gain access to a particular resource  
• Economies of scale  
• Risk and cost sharing  
• Gain access to a foreign market  
• Product and/or service development  
• Learning  
• Speed to market  
• Flexibility  
• Collective lobbying  
• Neutralizing or blocking competitors | Coordination: Formalization as a means to achieve concerted action: (division of labour; common language/communication; signaling device; fuel interaction processes)  
Control: Formalization as a means to restrain or direct behavior: (control of: the partner organization, deviation from objectives, process/pace setting; control from a distance; option to forgo control; trusting the partner)  
Legitimacy: Formalization as a means to persuade and convince stakeholders: (internal legitimacy; external legitimacy)  
Cognition and learning: Formalization as a means to make sense: (accuracy expectations; degree of ambiguity; focusing attention; completeness and consistency; force people to reflect and think; governability of the relationship; anticipation and mind-stretching; target for contraction; induce collective learning; generation of new ideas) | Formal  
• relationships  
• communication  
• clarity of roles and responsibilities  
• awareness of services  
• patient experience | Formal  
• clarity of roles and responsibilities of service providers  
• clarity of roles and responsibilities of organizations  
• accountability  
• bring together a range of stakeholders |
| **Disadvantages** | • Loss of proprietary information  
• Management complexities  
• Financial and organizational risks  
• Risk becoming dependent on a partner  
• Partial loss of decision autonomy  
• Partners’ ‘cultures’ may clash  
• Loss of organizational flexibility  
• Antitrust implications | Inhibiting: (creativity; innovation; flexibility; mutual accommodation)  
Reducing: (commitment and aspirations; initiatives that fall beyond specifications)  
Driving out: (intrinsic motivation)  
Inducing Risk: (risk of: areas of unilateral dependence; hold-up problems)  
Imposing: (high costs; incompleteness; limited enforceability)  
Creating Conditions: (Conditions for: data manipulation; organizational strife; short-termism) | Formal  
• lack of clarity of the written agreement  
• bureaucracy and red tape  
Informal  
• staff turnover  
• restructuring  
• lack of continuity of relationships  
• strategic plan to support relationships | Formal  
• cumbersome intake  
• cumbersome referral processes  
• inability of agreements to ensure access to or use of services  
Informal  
• lack of clarity of expectations  
• lack of clarity of roles or responsibilities  
• lack of clarity of accountability |

Note: *Adapted from Barringer and Harrison (2000, p. 385-386).  **Adapted from Vlaar et al. (2007b, p. 442-443).  ***Based on the results of the Phase III interviews.
Proposition 7: How managers enforce the various types of mechanisms they select and apply will influence the advantages and disadvantages of formalization experienced by staff members.

RQ 1: What are the various strategies that managers use to implement or monitor governance mechanisms?

RQ 2: What are the various strategies that managers use to implement or monitor operational mechanisms?

RQ 3: Do managers monitor the impact of mechanisms on staff activities and/or performance?

RQ 4: How explicit do managers make the governance and operational mechanisms? How are they communicated to staff members?

RQ 5: How do the mechanisms align (or not) with the organizational culture and philosophy towards partnerships and/or collaboration?

In summary, we have addressed a gap in the literature by proposing a pathway through which formalization may be associated with collaboration (i.e., administrative and service delivery collaboration), and evidence that administrators and service providers who participate in inter-organizational partnerships are knowledgeable about the main components of the proposed pathway. First, our observations acknowledge that participants identify both rational and relational reasons for engaging in partnerships. Second, our observations acknowledge that participants in both formal and informal partnerships identify both rational and relational mechanisms to support partnership activities, and administrative and service delivery collaboration. Finally, our observations acknowledge that informal partnerships have associated advantages and disadvantages that are experienced by staff members. In addition, the advantages and disadvantages experienced by staff members are likely to influence the tasks and processes that are
involved in administrative and service delivery collaboration. We can begin to anticipate how each
component of the pathway is related to the next, and ultimately how components of the
formalization process may influence levels of collaboration.

**Research Observations, Limitations & Recommendations**
The theoretical and practical implications of the research study are influenced by the
methodological limitations and tensions experienced in the study.

**Observations from the Research Process**
Throughout the implementation of the research project, several observations were made
that help inform future research efforts in this area or with this specific participant population. The
observations are organized according to the Phase of the study in which they were observed or
were most relevant.

During Phase I of the study, participants (from FHTs and CHCs) were asked to identify up to
three of their most important organizational partnerships with MHA organizations. What we did
not anticipate is that a number of the most important partnerships that FHTs and CHCs have are
currently with specialized MHA programs in hospitals or acute care centres. Originally, we had
defined MHA organizations as community-based organizations, and had not included hospitals or
acute care centres. We decided to include these partnerships in our analysis and data collection in
Phases II and III, rationalizing that partnerships were occurring at the program level (not necessarily
the organizational level), and that these relationships would be similar to those that occur with
community-based MHA organizations. A recommendation for the future is to ensure that these
types of partnerships (and organizations) are explicitly included in the description of potential
partnering organizations (and programs). A sub-group analysis would also help inform how similar
and/or different hospital-based MHA programs are to community-based MHA organizations.
During the transition from Phase I to Phase II of the study, we modified our sampling approach. Initially we had planned to use the top three most important partnerships identified in Phase I as our sampling pool for Phase II. However, based on our initial contacts with prospective participants, we received helpful feedback. First, not all partners agreed there was a partnership. For example, if a FHT had identified a partnership with a MHA organization, in some cases, when we contacted the MHA organization, we were unable to locate a contact person who could confirm that a partnership (either formal or informal) actually existed. We experienced this with larger organizations, when the partnership was informal (i.e., not written agreement or contract), and when multiple partnerships or other inter-organizational relationships existed. The potential methodological challenge is that we could be over reporting the number of partnerships with MHA organizations identified by FHTs and CHCs in this Phase of the study. A recommendation for the future is to ensure that a specific contact person is identified for each of the partnerships, from both of the partners involved. Staff members in FHTs, CHCs and MHA organizations are involved simultaneously in multiple formal and informal partnerships. It is also possible that there are partnerships (particularly informal ones) that staff members are engaged in, that our main organizational contact was not aware of (Phase I). From this perspective, we could be underreporting the number of partnerships that exist.

In addition, we observed that not all individuals in an organization or within a program are involved in a given formal or informal partnership. Thus, in collaboration with our main organizational contact, we had to identify all of the staff members who were perceived to be knowledgeable about the partnership in question, in order to be able to distribute the Phase II survey. This was an important step in the sampling process that required significant time and resources, in order to ensure that we were identifying all of the eligible participants for each organization.
During Phase III of the study, we conducted interviews with participants who had completed Phase II of the study, and we focused on their experiences with formal or informal partnerships. Since Phases II and III of the study were completed concurrently, we were not able to probe as deeply on some of the findings that emerged from the quantitative analysis from Phase II. For example, we conducted sub-group comparisons by organizational type and staff role, looking at the association between formalization and collaboration. Had we completed the quantitative analysis prior to conducting the interviews, we may have decided to revise some of our interview questions, or conduct more interviews to ensure saturation of key themes by organizational type or staff role. This is an area for future research, as it provides a rich opportunity for exploring and understanding the results of the sub-group analysis in more detail.

**Study Design**

As mentioned, the current study was part of a larger research project conducted through the University of Toronto. At times it was difficult to manage the various tensions that arose in meeting the overall research project objectives, while giving sufficient time, energy and attention required to adapt to the specific needs of the current study. For example, in Phase I, we did not collect data from the perspectives of the MHA organizations – data that would have been useful for organizational comparisons in Phase I and Phase II. In Phase III we did not interview service providers about their perspectives and experiences related to administrative collaboration, which would have provided a more complete discussion of the association between formalization and administrative collaboration. In addition, due to practical restrictions of the research study, we were unable to collect interview data during Phase III to a point of saturation, which would have provided a more robust assessment of the association between formalization and collaboration.
**Measurement**

Although we purposefully selected a dichotomous definition and measurement of formalization, it is possible that formalization may be more effectively conceptualized and measured on a continuum. For example, although we did not observe a significant difference in level of administrative or service delivery collaboration when we compared means by formal and informal partnerships, perhaps a more sensitive measure of formalization would have yielded different results.

Second, the PSAT has been recommended for use under the following conditions: minimum number of organizational partnerships is 5; partnerships must have existed for a minimum of 6 months; not to be used by external evaluators; and a minimum response rate of 65% is recommended. In some cases, there were fewer than 5 eligible respondents per organization. An assessment of the measurement tool used in this context might help contribute to its generalizability beyond the population and methods it was originally designed for.

Third, the CPQ was not originally developed or tested within an inter-organizational context. It is possible that core competencies for collaboration are similar in intra- and inter-organizational contexts, but slightly different constructs that require more distinct measurement. Further analysis of the CPQ within this population would contribute to its generalizability beyond the population and methods it was originally designed for.

**Methodological Tensions**

Conducting mixed methods research yields unique challenges for researchers and study participants. Bringing together two different types of data, in order to provide a broader or more in depth discussion of the study findings and objectives is challenging. First, deciding the best way to integrate the data sets, while also incorporating and building upon the conceptual foundation of the study, is an important process for the research team. It can be a lengthy and iterative process that
requires the entire research team to be engaged in a collaborative process to agree upon an
approach and desired outcome.

Second, the quality of the data generated (by either data set) may not lend itself to a perfect
integration of findings. For example, in Phase II of the study we observed differences in the
association between formalization and administrative collaboration when we compared the means
by organizational type. Due to the study design and pragmatics of data collection, we had
completed the qualitative interviews prior to completing the analysis for Phase II. Thus, the larger
research project drove the speed and order in which the phases of the research were conducted.
We did not have the opportunity to probe more deeply in our interviews in Phase III with
administrators to explore their perceptions about the possible influence of organizational type.

Finally, another challenge in conducting mixed methods research is related to the
integration of study findings and preparation of manuscripts for publication. Creating a manuscript
that meets the proposed guidelines for publishing mixed methods research (Creswell & Tashakkori,
2007; Mertens, 2011), while adhering to a given journal’s submission requirements (e.g., length of
manuscript, number of references, journal objectives, reviewer criteria), significantly restricts the
ability of researchers to present their research in a comprehensive way. Research objectives and
findings end up being divided into several related research papers, in order to sufficiently present
the necessary components of an academic paper for publication.

Practical Implications
Practical implications are provided for organizational leaders and policy makers.

Implications for Organizational Leaders
Determining the Level of Formalization for a Partnership

Since the current study operates within a generation of research that proposes to take a less
deterministic approach to understanding the association between formalization and collaboration,
the practical implications for organizational leaders are organized as a series of questions to help them clarify and organize their thinking and decision-making.

We propose there are a number of factors that organizational leaders will need to consider when deciding the level of formalization for a partnership.

Leaders may consider the following questions:

1. What is the environmental context of the organization relative to the partnership?
2. What are the organizational characteristics relative to the partnership?
3. Is the partnership imposed or the result of an emergent process?
4. Who will be involved in the decision-making process? What is the manager’s knowledge and experience with formal and informal partnerships?
5. What are the perceived rational (exchange-focused) and relational (relationship-focused) benefits for the partnership?
6. What are the perceived co-exploration (focus on the new) and co-exploitation (focus on the existing) activities?

Once a level of formalization is selected, leaders may consider the following questions:

1. What rational and/or relational mechanisms will be selected and implemented to support the partnership?
2. How will the mechanisms be enforced or monitored?
3. What are the possible advantages and disadvantages to the mechanisms implemented? From the perspective of administrators? From the perspective of service providers? From the perspective of your partners?
Fostering Personal Relationships

The importance of personal relationships cannot be taken for granted, regardless of the formality of the partnership, or the staff role. Traditionally considered a ‘soft skill’, along with communication, organizations give little conscious attention and resources to fostering personal relationships among staff in an ongoing way. Although interview participants reported an emphasis on the emergence of partnerships (founded on personal relationships based on trust and mutual respect), they also experienced frustrations with a lack of clarity around roles, responsibilities, expectations and accountability.

Organizational leaders can create opportunities for staff to connect across organizations – and these experiences must have meaning, from both an organizational perspective and a staff perspective. Staff members want to solve real time problems and challenges in their job, share their success stories, learn from one another, and find new, creative and innovative ways to work together. Shared learning opportunities offer the following benefits: enhance knowledge and skill (e.g., expand scope of practice); increase understanding of professional roles and responsibilities; strengthen communication; and overall, foster personal relationships and an awareness of the interdependence among partners.

Implications for the Policy Setting

Four key implications are offered for stakeholders within the policy setting. First, continue to monitor the frequency and quality of partnerships across Ontario, so we can track activities as partnerships evolve over time, and use this information to shape policies and resource allocations that support community partnerships. Second, broaden the environmental scan to include expanded human services (i.e., social services, justice, and education). It is clear that the human experience crosses many service systems and we must develop a more comprehensive understanding of how these systems work together. Third, create opportunities for people to share
best practices at the front line level. Service providers and patients have historically been neglected from decision-making processes, and yet their experiences and understanding of best practices can be very informative in guiding policymakers in their planning, implementation and evaluation efforts. Finally, invest in the development of local organizational leaders and contribute to a conscious cultural shift towards a more mindful, interdependent system of organizations, services and relationships.

**Conclusion**

In this study, we have examined the association between the formalization of inter-organizational structures and collaboration as a staff practice, and explored the experiences of administrators and service providers who work in both formal and informal partnerships. The results suggest that there is not a significant association between formalization and collaboration. We have addressed a gap in the literature by proposing a pathway through which formalization may be associated with collaboration, and evidence that staff members who participate in inter-organizational partnerships are knowledgeable about the main components of the proposed pathway. The results of the study provide opportunities for future research in order to help improve the quality and accessibility of services to adults with complex mental health and addiction needs.
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Report prepared for the Canadian Health Services Research Foundation.


Appendix A: Phase I Survey

The ‘current state of collaboration’ among primary care and mental health and addictions agencies in Ontario

(administered using Survey Monkey)

Instructions:

Please do not write your name, or any identifying information on the survey. In order to keep your responses confidential, you will be asked to assign a code provided to you by the RA that is linked to your name on a master list. The codes and the master list of names will be used by the RA to re-contact participants in the event that they are invited to participate in phase III or in the event that you withdraw from the study. The master list of survey codes and names will be kept separate from the electronic survey files so that the survey cannot be linked to you personally.

Returning your completed survey implies your consent to participate in Phase II of the research and to be contacted and invited to participate in Phase III of the study.

For additional information, please read the Information letter and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have any questions, please contact the Principal Investigator, Enette Pauze (416-809-4270), or the Project Coordinator, Elisa Hollenberg (416-340-4900 ext. 6576).

Survey code assigned to you by the RA: ______________________
Section A: Background Information

General demographic information about the respondent, including:
1. What is your current position title?
2. How long have you occupied your current position? ___#___ years ___#___ months in current position
3. What is your age?
4. Gender: male or female
5. What is the highest form of education you have completed?
   a. High school
   b. Undergraduate
   c. Graduate
   d. Diploma

General information about the organization, including:
6. Is your organization a FHT, CHC, or CHS Satellite? (select one)
7. In what LHIN is your organization located?
8. What is the organization’s annual operating budget?
9. What population size do you serve?
10. When was your organization established? ___#___ year ___#___ month
11. What is the governance model for your organization
   a. Community-based
   b. Provider-based
   c. Mixed (community and provider)
   d. Other (please specify):

12. Does your organization have a population focus on adult mental health/addiction? (y/n) (Population focus is defined as being a strategic or organizational objective of the organization.)

13. Do you have mental health/addiction specialists on your team? (y/n) If yes, please provide additional information:
   a. How many individual positions exist?
   b. What is the total FTE for all of the positions combined?
   c. What are the professions represented?

14. Has your organization received funding to hire a mental health/addiction specialist? (y/n) If yes, please provide additional information:
   d. How much funding has been received?
   e. How many positions will be available?
   f. What will be the total FTE for all of the positions combined?
   g. Has your organization experienced difficulties in recruiting eligible staff? (y/n)
Section B: Inter-Organizational Partnerships

15. Organizational partnerships: “Partnerships included formal and informal linkages that connect two organizations to a common purpose or goal.”
   a. How many partners does the organization currently have with other health provider organizations? Please consider primary care, mental health and addiction organizations from across Ontario (insert list).
   b. What are the names of each partnering organization? (select from a list, option to add others)
   c. How long has each partnership existed? When was it formed (year, month)?
   d. How active is each partnership? Do members of the two organizations interact:
      i. Daily
      ii. Once per week
      iii. Several times per week
      iv. 2-3 times per month
      v. Once per month
   e. How many individuals within your organization are involved in each partnership? (e.g., involved in administrative and/or clinical activities)
   f. Does your partnership share a formal written agreement of any kind? (e.g., service agreement, bylaw, written procedures) (y/n)

16. In some cases, there may be more than two organizations that have a formal or informal partnership, called a ‘network’. Organizations within these networks share a common goal related to providing services to adults with mental health and/or addiction needs.
   a. Does your organization participate in a network of this kind? y/n
   b. What are the names of each partnering organization in the network? (select from a list, option to add others)
   c. How long has each network existed? When was it formed (year, month)?
   d. How many individuals within your organization are involved in the network? (e.g., involved in administrative and/or clinical activities)
   e. Does your network share a formal written agreement of any kind? (e.g., service agreement, bylaw, written procedures) (y/n)
Section C: Formality of Organizational Structures

Please select up to 3 of your current organizational partnerships (dyads) to provide the following information. If your organization has more than 3 partnership dyads, please select the partnership dyads are most significant in their role in providing services to adults with mental health and/or addiction needs.

1. Partnership dyad #1 ___________
2. Partnership dyad #2 ___________
3. Partnership dyad #3 ___________

For each partnership dyad, please answer the following questions:
1. Does your partnership share a formal written agreement of any kind? (y/n)
2. If yes, please specify the type of agreement (e.g., service agreement, bylaw, policies/procedures):
3. If yes, which of the following service ties are outlined, described or included as part of the agreement? (check all that apply):

   Administrative:
   - Administrative coordination/governance structure
   - Inter-agency meetings
   - Shared administrative information
   - Shared financial resources
   - Shared human resources
   - Shared resources (other) (e.g., space)
   - Other: __________

   Service Delivery:
   - Joint programs in mental health and/or addictions
   - Joint services (e.g., service referrals, received/sent)
   - Case coordination
   - Joint consultations
   - Shared patient/client information
   - Common intake and/or assessment forms
   - Common management system
   - Co-location of providers
   - Other: __________
Appendix B: Phase II Survey

The formalization of primary care and mental health and addictions organizational partnerships in Ontario

(administered using Survey Monkey)

Instructions:

1. Please do not write your name, or any identifying information on the survey. In order to keep your responses confidential, you will be asked to assign a code provided to you by the RA that is linked to your name on a master list. The codes and the master list of names will be used by the RA to re-contact participants in the event that they are invited to participate in an interview for phase III of the research or in the event that you withdraw from the study. The master list of survey codes and names will be kept separate from the electronic survey files so that the survey cannot be linked to you personally.

Submitting your completed survey on Survey Monkey implies your consent to participate in Phase III of the study.

For additional information, please read the Information letter and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have any questions, please contact the Principal Investigator, Enette Pauze (416-809-4270), or the Project Coordinator, Elisa Hollenberg (416-340-4900 ext. 6576).

Survey code assigned to you by the RA: ______________________

2. Please respond to the following series of questions about your organizational partnership with ________ (insert name of specific organization).

3. Selected participants include individuals who interact with a partner agency (or agencies) to provide services for adults seeking access to services across primary care, mental health and addiction organizations. This person will be someone who would know about how the partnership works and its purpose, who leads this partnership, what resources are required, how decisions are made and its opportunities and challenges. Individuals identified may be a mixture of service providers and administrators.

You may be knowledgeable about both partnership quality and level of interprofessional collaboration, or only one of the variables. Thus, you may opt to complete only the relevant sections of the survey as follows:

i. If you are knowledgeable about both partnership quality and the level of interprofessional collaboration, please complete all sections of the survey.

ii. If you are knowledgeable about partnership quality only, then please complete section A only.

iii. If you are knowledgeable about interprofessional collaboration only, please complete section B only.
Section A: Partnership Quality

Partnership Self-Assessment Tool

Synergy

Please think about the people and organizations that are participants in your partnership.

a. By working together, how well are these partners able to identify new and creative ways to solve problems?
   [ ] Extremely well  
   [ ] Very well  
   [ ] Somewhat well  
   [ ] Not so well  
   [ ] Not well at all

b. By working together, how well are these partners able to include the views and priorities of the people affected by the partnership’s work?
   [ ] Extremely well  
   [ ] Very well  
   [ ] Somewhat well  
   [ ] Not so well  
   [ ] Not well at all

c. By working together, how well are these partners able to develop goals that are widely understood and supported among partners?
   [ ] Extremely well  
   [ ] Very well  
   [ ] Somewhat well  
   [ ] Not so well  
   [ ] Not well at all

d. By working together, how well are these partners able to identify how different services and programs in the community relate to the problems the partnership is trying to address?
   [ ] Extremely well  
   [ ] Very well  
   [ ] Somewhat well  
   [ ] Not so well  
   [ ] Not well at all

e. By working together, how well are these partners able to respond to the needs and problems of the community?
   [ ] Extremely well  
   [ ] Very well  
   [ ] Somewhat well  
   [ ] Not so well  
   [ ] Not well at all
f. By working together, how well are these partners able to implement strategies that are most likely to work in the community?
[ ] Extremely well
[ ] Very well
[ ] Somewhat well
[ ] Not so well
[ ] Not well at all

g. By working together, how well are these partners able to obtain support from individuals and organizations in the community that can either block the partnership’s plans or help move them forward?
[ ] Extremely well
[ ] Very well
[ ] Somewhat well
[ ] Not so well
[ ] Not well at all

h. By working together, how well are these partners able to carry out comprehensive activities that connect multiple services, programs, or systems?
[ ] Extremely well
[ ] Very well
[ ] Somewhat well
[ ] Not so well
[ ] Not well at all

i. By working together, how well are these partners able to clearly communicate to people in the community how the partnership’s actions will address problems that are important to them?
[ ] Extremely well
[ ] Very well
[ ] Somewhat well
[ ] Not so well
[ ] Not well at all

Leadership

Please think about all of the people who provide either formal or informal leadership in this partnership. Please rate the total effectiveness of your partnership’s leadership in each of the following areas:

a. Taking responsibility for the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know
b. Inspiring or motivating people involved in the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

c. Empowering people involved in the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

d. Communicating the vision of the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

e. Working to develop a common language within the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

Please rate the total effectiveness of your partnership’s leadership in:

f. Fostering respect, trust, inclusiveness, and openness in the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

g. Creating an environment where differences of opinion can be voiced
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
h. Resolving conflict among partners
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

i. Combining the perspectives, resources, and skills of partners
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

j. Helping the partnership be creative and look at things differently
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

Please rate the total effectiveness of your partnership’s leadership in:
k. Recruiting diverse people and organizations into the partnership
[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

Efficiency

1. Please choose the statement that best describes how well your partnership uses the partners’ financial resources.
[ ] The partnership makes excellent use of partners’ financial resources.
[ ] The partnership makes very good use of partners’ financial resources.
[ ] The partnership makes good use of partners’ financial resources.
[ ] The partnership makes fair use of partners’ financial resources.
[ ] The partnership makes poor use of partners’ financial resources.
2. Please choose the statement that best describes how well your partnership uses the partners’ in-kind resources (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods).

[ ] The partnership makes excellent use of partners’ in-kind resources.
[ ] The partnership makes very good use of partners’ in-kind resources.
[ ] The partnership makes good use of partners’ in-kind resources.
[ ] The partnership makes fair use of partners’ in-kind resources.
[ ] The partnership makes poor use of partners’ in-kind resources.

3. Please choose the statement that best describes how well your partnership uses the partners’ time.

[ ] The partnership makes excellent use of partners’ time.
[ ] The partnership makes very good use of partners’ time.
[ ] The partnership makes good use of partners’ time.
[ ] The partnership makes fair use of partners’ time.
[ ] The partnership makes poor use of partners’ time.
Section B: Interprofessional Collaboration

Please answer the following two part questionnaire by indicating the number that best applies to you for each statement. There are no “right” or “wrong” answers. It is important that you respond to each statement. If you work with more than one collaborating partner consider your overall collaboration and not the collaboration with a specific individual.

PART 1: Collaborative Practice Questionnaire – Measure of current collaboration

Consider your current overall experience of collaboration between you and your collaborating partners (the family physician(s), the nurse practitioner(s), and other team members within your practice). Please place a check mark under the number that represents your current degree of agreement or disagreement with each statement.

<table>
<thead>
<tr>
<th>RATING SCALE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
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<td>Agree</td>
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<td>Strongly Agree</td>
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</table>

My collaborating partner(s) and I:

1. Plan together to make decisions about the care for the patients (when appropriate)

2. Communicate openly as decisions are made about patient care

3. Share responsibility for decisions made about patient care

4. Co-operate in making decisions about patient care

5. Consider all professions’ concerns in making decisions about patient care

6. Co-ordinate implementation of a shared plan for patient care

7. Demonstrate trust in one another’s decision making ability in making shared decisions about patient care

8. Respect one another’s knowledge and skills in making shared decisions about patient care

9. Fully collaborate in making shared decisions about patient care
PART 2 - Interprofessional Collaboration Activities

How often do you engage in the following activities when working with other service providers across organizations in the partnership?:

**Rating Scale**

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<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Not at all</td>
<td>Once per month</td>
<td>2-3 times per month</td>
<td>Once per week</td>
<td>Several times per week</td>
<td>Daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Co-location of services</td>
<td></td>
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<tr>
<td>2. Consultation with formal feedback to referring/primary provider</td>
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<tr>
<td>3. Ongoing working relationship</td>
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<td>4. Opportunities for case discussion and review</td>
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<td>5. Shared assessment</td>
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<td>6. Shared decision-making</td>
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<td>7. Shared treatment planning</td>
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<tr>
<td>8. Delegated clinical activities involving feedback of patient/client information to the referring/primary provider</td>
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<tr>
<td>9. Designated clinical activities which do not involve feedback to the referring/primary provider</td>
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Appendix C: Phase III Interview Guide (Administrators)

Description of Partnership
[Confirm and enhance the description of the partnership.]

Your partnership with X organization has been identified as [formal or informal]. A formal relationship is defined as a shared written agreement between the two organizations.

1. Can you briefly describe the rational for having the [formal or informal] partnership?
   a. [formal] Are the details of the agreement available to staff members? If so who, and how are they accessed?
   b. [informal] How knowledgeable are staff members about the nature of the informal partnership? How is this information shared among staff?
2. What are the processes or steps that are required to support [formal or informal] partnership activities across the two organizations?
3. Does your organization engage in joint meetings/activities with staff from X organization? If so, can you describe what the joint meetings/activities looks like?
4. Can you describe a typical patient/client experience, as he/she moves between the two organizations?

Partnership Synergy
[The degree to which a partnership’s collaborative process successfully combines its participants’ perspectives, knowledge, and skills. There are six dimensions of partnership functioning: leadership, administration and management, partnership efficiency, nonfinancial resources, partner involvement challenges, and community-related challenges. In previous studies, synergy was most closely related to leadership effectiveness and partnership efficiency.]

1. How has having a [formal or informal] partnership impacted your experience of working with members of X organization?
2. How well has the partnership process been able to successfully combine its participants’ perspectives, knowledge and/or skill? Can you give specific examples?
3. What specifically about the formality of the relationship SUPPORTS/EHANCES your role?
   a. Enhances the role of service provider?
   b. Enhances patient/client experiences?
4. What specifically about the formality of the relationship HINDERS your role?
   a. Hinders the role of service providers?
   b. Hinders patient/client experiences?

Leadership Effectiveness
[Measure attributes of leadership that may be critical for achieving high levels of partnership synergy. Respondents were asked to rate the total effectiveness of the formal and informal leadership in the partnership in the following areas: taking responsibility for the partnership; inspiring and motivating partners; empowering partners; working to develop a common language within the partnership; fostering respect, trust, inclusiveness, and openness in the partnership; creating an environment where differences of opinion can be voiced; resolving conflict among]
partners; combining the perspectives, resources, and skills of partners; and helping the partnership look at things differently and be creative.]

1. How effective do you feel the [formal or informal] leadership of the partnership is?
   a. How has leadership effectiveness impacted your role?
   b. The role of service providers?
   c. The experience of patients/clients?

**Partnership Efficiency**
[Respondents were asked how much they agreed or disagreed with the following statements: the partnership makes good use of partners’ financial resources, the partnership makes good use of partners’ in-kind resources, and the partnership makes good use of partners’ time.]

1. What is your opinion on the added value of working in [formal or informal] partnership with staff members from X organization?
   a. What about other mental health, addiction and primary care organizations?

**Closing Questions**

1. Ideally, how should the [formal or informal] partnership be designed to enhance relationships across organizations?
   a. What would you like to see/experience more of?
   b. What would you like to see/experience less of?
   c. What is already working well?
   d. How might these changes impact the experience of patients/clients?

2. Is there anything else you would like to share about your experience?
Appendix D: Phase III Interview Guide (Service Providers)

Description of the Collaboration
[Confirm and enhance the description of the inter-org collaboration.]

Your partnership with X organization has been identified as [formal or informal]. A formal relationship is defined as a shared written agreement between the two organizations.

1. Can you briefly describe the rational for having the [formal or informal] partnership?
   a. [formal] Are the details of the agreement available to staff members? If so who, and how are they accessed?
   b. [informal] How knowledgeable are staff members about the nature of the informal partnership? How is this information shared among staff?

2. How often do you work with providers from X organization?
   a. How many providers from other organizations have you worked with over the past month?
   b. Do you participate in joint consultations with providers from X organizations?

3. What are the processes or steps that are required to support collaborative activities across the two organizations?

4. Can you describe what a typical collaborative experience looks like when working with providers from X organization? [consider the following interprofessional care activities, from survey]
   a. Co-location of services
   b. Consultation with formal feedback to referring/primary provider
   c. Ongoing working relationship
   d. Opportunities for case discussion and review
   e. Shared assessment
   f. Shared decision-making
   g. Shared treatment planning
   h. Delegated clinical activities involving feedback of patient/client information to the referring/primary provider
   i. Designated clinical activities which do not involve feedback to the referring/primary provider

Level of interprofessional collaboration
[Key characteristics of interprofessional collaboration (called ‘core competencies’) include: knowledge of healthcare professional roles; ability to communicate effectively with other health professionals; ability to reflect the effect of health professionals’ roles and attitudes related to mutual trust; and willingness to collaborate.]

1. What has your experience been like, in working with providers from X organization?
2. How effective do you feel the interprofessional collaboration is among providers who work across the two organizations? Can you give an example?
3. How has the [formal or informal] nature of the partnership specifically impacted your ability to work with providers from X organization?
4. What is your opinion on the value of working collaboratively with providers from X organization?
   a. What about other mental health, addiction and primary care organizations?
   b. What would you like to see/experience more of?
   c. What would you like to see/experience less of?
5. How do you feel about your relationships with providers from X organization?
   a. What are some of the challenges? Can you give an example?
   b. What have been some of the successes? Can you give an example?
   c. How has the relationship impacted patient/client care?

Closing Questions
1. How should inter-organizational partnerships be designed to better support the ability of service providers to work collaboratively across organizations?
   a. What would you like to see/experience more of?
   b. What would you like to see/experience less of?
   c. What is already working well?
   d. How might these changes impact the experience of patients/clients?
2. Is there anything else you would like to share about your experience?
Appendix E: Administrator Interview Coding Key

**Partnership Description (PD)**
- Rationale (PD-R)
- Sharing of Formal Agreement with staff (PD-SA)
- Knowledge of partnership (PD-K)
- Partnership structures/processes (PD-SP)
- Partnership Meetings (PD-M)
- Patient Example (PD-E-PT)
- Example (PD-E)

**Partnership Synergy (PS)**
- Partnership benefits (PS-PB)
  - Admin (PS-PB-A)
  - Provider (PS-PB-PR)
  - Patient (PS-PB-PT)
- Partnership challenges (PC)
  - Admin (PS-PC-A)
  - Provider (PS-PC-PR)
  - Patient (PC-PC-PT)
- Partnership Synergy Example (PS-E)

**Leadership Effectiveness (LE)**
- Leadership Example (LE-E)
  - Admin (LE-E-A)
  - Providers (LE-E-PR)
  - Patients (LE-E-PT)

**Partnership Efficiency (PE)**
- Example (PE-E)

**Open ended Ideal (OE-I)**
Appendix F: Service Provider Interview Coding Key

**Partnership Description (PD)**
- Rationale (PD-R)
- Sharing of Formal Agreement with staff (PD-SA)
- Knowledge of partnership (PD-K)
- Frequency Activity (PD-FA)
- Team Description (size and role) (PD-TD)
- Partnership admin structures/processes (PD-SP)
  - SP Facilitators (PD-SP-FA)
  - SP Barriers (PD-SP-B)
  - SP Example (PD-E-SP)

**IPC Description (IPC-D)**
- Barriers (IPC-B)
- Facilitators (IPC-FA)
- Example (not pt care) (IPC-E)

**Level of IPC (IPC)**
- IPC Effectiveness (IPC-EF)
- Effectiveness Impact (IPC-EI)
  - Provider (IPC-EI-PR)
  - Patient (IPC-EI-PT)
- Value of IPC (IPC-V)
- Example (IPC-E)
- Comparison (IPC-C)

**IP Care Activity (ICA)**
- Joint consults (ICA-1)
- Co-location of services (ICA-2)
- Consultation with formal feedback to referring/primary provider (ICA-3)
- Ongoing working relationship (ICA-4)
- Opportunities for case discussion and review (ICA-5)
- Shared assessment (ICA-6)
- Shared decision-making (ICA-7)
- Shared treatment planning (ICA-8)
- Delegated (ICA-9)
- Designated (ICA-10)

**Open ended (OE)**
- Ideal (OE-I)
- Partnership Comparison (OE-C)